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Section 6. SSI Program Description

The Supplemental Security Income (SSI) program is a means-tested, federally administered income assistance program authorized by title XVI of the Social Security Act. Established by the 1972 amendments to the Social Security Act (Public Law 92-603) and begun in 1974, SSI provides monthly cash payments in accordance with uniform, nationwide eligibility requirements to needy aged, blind and disabled persons. The SSI program replaced the former Federal grants to the States for old-age assistance, aid to the blind and aid to the permanently disabled. These grants continue in Guam, Puerto Rico and the Virgin Islands. SSI, however, operates in the Commonwealth of the Northern Mariana Islands.

Table 6-1 summarizes the trends in the SSI program since its inception in 1974:

(1) The number of recipients on SSI has risen from nearly 4 million in 1974 to nearly 6 million in December 1993. The number of SSI recipients declined early in the program as the number of aged individuals on SSI declined, but that trend reversed in the mid-1980s as rapid growth in disabled recipients outstripped the minimal change in the elderly and blind SSI populations. From 1984 through 1993, the disabled population on SSI grew at an annual average rate of about 9.2 percent.

(2) Total annual benefits paid under the SSI program rose at an average rate of 7.9 percent from about \$5.3 billion in 1974 to \$23.6 billion in 1993. After adjusting for inflation, however, total annual benefits rose by an annual average rate of 2.2 percent.

(3) The monthly Federal benefit rates for individuals and couples rose from \$140 and \$210 in 1974 to \$446 and \$669 in 1994, respectively. Nearly all of these changes resulted from the statutory indexation of the Federal benefit rates to the Consumer Price Index (CPI).

(4) The proportion of SSI recipients receiving Social Security benefits declined from nearly 53 percent in 1974 to about 40 percent in 1993. The fraction of SSI recipients receiving some other type of unearned income rose from about 11 percent in 1974 to 13 percent in 1993, and the fraction with earnings jumped from about 3 percent in 1974 to more than 4 percent in December 1993.

(5) The Federal benefit rate as a percent of the appropriate poverty level for individuals has ranged from 72 to 77 percent and is currently 75 percent; for couples it has ranged from 86 to 91 percent and is currently at 89.5 percent. Most States supplement the Federal benefit for at least some participants.

(6) The SSI program pays benefits to children who are blind or have other disabilities. Some of the increases in participation since 1991 reflect the revised definition of disability for

children as a result of the Supreme Court's decision in the *Sullivan v. Zebley* case.

BASIC ELIGIBILITY

To qualify for SSI payments, a person must satisfy the program criteria for age, blindness or disability. The aged are defined as persons 65 years and older. The blind are individuals with 20/200 vision or less with the use of a correcting lens in the person's better eye, or those with tunnel vision of 20 degrees or less. Disabled individuals are those unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death or that has lasted, or can be expected to last, for a continuous period of at least 12 months.

Also, a child under age 18 who has an impairment of comparable severity with that of an adult may be considered disabled. On February 20, 1990, the Supreme Court affirmed the Court of Appeals (Third Circuit) decision in *Sullivan v. Zebley*. As a result, SSA is completing a reevaluation of childhood disability claims for SSI benefits which were denied because the child's functional limitations were not considered in making the decision on the severity of the impairment. Federal regulations that revise the disability evaluation and determination process for SSI claims of disabled children (i.e., implementing the *Zebley* decision) were issued in February 1991.

A person also must be needy, i.e., have limited income and resources (discussed later) to be eligible for SSI. However, disabled SSI recipients whose incomes exceed the limits because of earnings but who continue to be medically disabled, may continue to be eligible for Medicaid. In addition, to qualify for SSI, a person must (1) be a U.S. citizen or an immigrant lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law and, (2) be a resident of the United States or the Northern Mariana Islands, or a child of military personnel stationed outside the United States.

TABLE 6-1.—SUPPLEMENTAL SECURITY INCOME SUMMARY

[Selected calendar years 1974-93]

Item	1974	1978	1980	1984	1986	1988	1990	1991	1992	1993
Recipients: ¹										
Total	3,996,064	4,216,925	4,142,017	4,029,333	4,269,184	4,463,869	4,817,127	5,118,470	5,566,189	5,984,300
Aged	2,285,909	1,967,900	1,807,776	1,530,289	1,473,428	1,433,420	1,454,041	1,464,584	1,471,022	1,474,852
Blind	74,616	77,135	78,401	80,524	83,115	82,864	83,686	84,549	85,400	85,456
Disabled	1,635,539	2,171,890	2,255,840	2,418,522	2,712,641	2,947,585	3,279,400	3,569,237	4,009,767	4,424,022
Number with Section 1619(a)	NA	NA	NA	406 (8,884)	992 (1,861)	19,920	213,994	15,531	17,603	18,597
Number with Section 1619(b)	NA	NA	NA	6,804	8,106	15,625	23,517	26,852	31,649	34,293
Annual Payments (in millions):										
Total	\$5,246	\$6,552	\$7,940	\$10,372	\$12,081	\$13,786	\$16,599	\$18,534	\$22,238	\$23,991
Federal Benefits	3,833	4,881	5,866	8,281	9,498	10,734	12,894	14,765	18,247	20,722
Federal Admin. State Supp	1,264	1,491	1,848	1,792	2,243	2,671	3,239	3,231	3,435	3,270
State Admin. State Supp	149	180	226	299	340	381	466	538	556	564
Annual Payments (in millions of 1992 dollars)	\$14,929	\$14,099	\$13,519	\$14,006	\$15,465	\$16,350	\$17,818	\$19,092	\$22,238	\$23,841
Monthly Federal Benefits Rates:										
Individuals	\$140.00	\$177.80	\$208.20	\$314.00	\$336.00	\$354.00	\$386.00	\$407.00	\$422.00	\$434.00
Couples	210.00	266.70	312.30	472.00	504.00	532.00	579.00	610.00	633.00	652.00
Average Federal SSI payments: ¹										
All Recipients	\$95.11	\$111.98	\$143.35	\$196.16	\$215.40	\$227.49	\$261.47	\$286.03	\$329.74	\$317.41
Aged Individuals	78.48	91.22	112.45	143.24	151.38	159.36	175.29	186.28	195.86	204.45
Aged Couples	93.02	120.48	157.56	221.98	246.07	273.18	322.82	414.26	448.61	478.42
Average Federally administered: ¹										
State supplementation	\$70.92	\$75.00	\$99.15	\$97.61	\$115.41	\$122.68	\$139.79	\$130.55	\$118.08	\$108.50
Income of Recipients Percent with: ¹										
Social Security benefits	52.7	51.7	51.0	49.6	48.9	47.8	45.9	44.3	41.3	40.1
Other unearned income	10.5	11.5	11.0	11.2	12.1	12.4	13.0	14.1	14.5	13.4
Earnings	2.8	3.1	3.2	3.5	3.9	4.4	4.7	4.6	4.4	4.3
Average amount of: ¹										
Social Security benefits	\$120.01	\$156.50	\$196.94	\$250.61	\$263.29	\$286.49	\$318.57	\$329.19	\$335.72	\$338.85
Other unearned income	61.10	66.93	74.35	84.56	86.40	85.92	98.13	94.71	91.96	100.44
Earnings	80.00	99.32	106.95	126.47	142.17	173.09	195.64	206.86	207.55	210.22

TABLE 6-1.—SUPPLEMENTAL SECURITY INCOME SUMMARY—Continued
[Selected calendar years 1974-93]

Item	1974	1978	1980	1984	1986	1988	1990	1991	1992	1993
Poverty Thresholds (Age 65 and over):										
Individual	\$2,364	\$3,127	\$3,949	\$4,979	\$5,255	\$5,674	\$6,268	\$6,532	\$6,729	\$6,930
Couple	2,982	3,944	4,983	6,282	6,630	7,158	7,905	8,241	8,489	8,741
Federal Benefit Rate as a percent of Poverty:										
Individual	74.1	72.7	72.3	75.6	76.7	74.9	73.9	74.8	75.3	75.2
Couple	88.1	86.4	86.0	90.2	91.2	89.2	87.9	88.8	89.5	89.5

¹ December data.

² The decrease in 1990(a) participants in 1990 was caused by the increase in the substantial gainful activity level to \$500 monthly.

³ Fiscal year 1992 data.

Source: Social Security Bulletin, Annual Statistical Supplement, and unpublished data.

Further, since SSI payments are reduced by other income, applicants and recipients must apply for any other money benefits due them. The Social Security Administration works with recipients and helps them get any other benefits for which they are eligible.

Persons who are disabled because of drug addiction or alcoholism must accept appropriate treatment for their addictions as a condition of SSI eligibility. Additionally, except for children of military personnel, persons outside of the United States for a month are not eligible for SSI. Blind or disabled children of military personnel who accompany their parents to overseas duty stations may be eligible for SSI if they were eligible in the month before they left the United States.

People who get SSI checks can get Social Security checks, too, if they are eligible for them. However, a person cannot get SSI payments and participate in the AFDC program. If a parent or child is eligible under both programs, the parent can choose whichever best suits the family.

Residents of public institutions for a full calendar month are ineligible for SSI unless one of the following exceptions applies:

1. The public institution is a medical treatment facility and Medicaid pays more than 50 percent of the cost of care.

2. The individual is residing in a publicly operated community residence which serves no more than 16 residents. Such a facility must provide an alternative living arrangement to a large institution and be residential (i.e., not a correctional, educational or medical facility).

3. The public institution is a public emergency shelter for the homeless. Such a facility provides food, a place to sleep, and some services to homeless individuals on a temporary basis. Payments to a resident of a public emergency shelter for the homeless are limited to no more than 6 months in any 9-month period.

4. The individual is in a public institution primarily to receive educational or vocational training. To qualify, the training must be an approved program and must be designed to prepare an individual for gainful employment.

5. The individual was eligible for SSI under one of the special provisions of section 1619 of the Social Security Act (see section on Special SSI Benefits, Medicaid Services, and Related Provisions for the Working Disabled) in the month preceding the first full month of residency in a medical or psychiatric institution which agrees to permit the individual to retain benefit payments. Payment may be made for the first full month of institutionalization and the subsequent month.

6. A physician certifies that the recipient's stay in a medical facility is likely not to exceed 3 months and the recipient needs to continue to maintain and provide for the expenses of the home to which he may return. Payments may be made for up to the first 3 months of institutionalization.

ELIGIBILITY OF SSI RECIPIENTS FOR SOCIAL SECURITY

SSI law requires that SSI applicants file for all other benefits for which they may be entitled. Since its inception SSI has been viewed as the "program of last resort." That is, after evaluating all

other income, SSI pays what is necessary to bring an individual to the statutorily prescribed income "floor." As of September 1993, 40.7 percent of all SSI recipients also received Social Security benefits (65 percent of aged SSI recipients). Social Security benefits are the single highest source of income for SSI recipients. The SSI program considers Social Security benefits unearned income and thus counts all but \$20 monthly in determining the SSI benefit amount.

ELIGIBILITY OF SSI RECIPIENTS FOR AFDC

An *individual* cannot receive both SSI payments and AFDC benefits and, if eligible for both, must choose which benefit to receive. Generally, the AFDC agency encourages individuals to file for SSI and, once the SSI payments start, the individual is removed from the AFDC filing unit.

ELIGIBILITY OF SSI RECIPIENTS FOR MEDICAID

States have three options as to how they treat SSI recipients in relation to Medicaid eligibility. Section 1634 of SSI law allows the Social Security Administration to enter into agreements with States to cover all SSI recipients with Medicaid eligibility. SSI recipients are not required to make a separate application for Medicaid under this arrangement. Thirty-one States and the District of Columbia chose this option, and SSI recipients in these States account for approximately 79 percent of all SSI recipients nationwide.

Under the second option, States elect to provide Medicaid eligibility for all SSI recipients, but only if the recipient completes a separate application with the State agency which administers the Medicaid program. The seven States of Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah and the Commonwealth of the Northern Mariana Islands affecting about 2.4 percent of SSI recipients nationwide, have elected this option.

The third and most restrictive option is known as the "209(b)" option, under which States may impose Medicaid eligibility criteria which are more restrictive than SSI criteria, so long as the criteria chosen are not more restrictive than the State's approved Medicaid State plan in January 1972. The 209(b) States may be more restrictive in defining blindness or disability, and/or more restrictive in their financial requirements for eligibility, and/or require a Medicaid application with the State. However, aged, blind, and disabled SSI recipients who are Medicaid applicants must be allowed to spend-down in 209(b) States, regardless of whether or not the State has a medically needy program. Twelve States use the 209(b) option for Medicaid coverage of aged, blind, and disabled SSI recipients. About 18.3 percent of the SSI recipient population nationwide lives in these 209(b) States. The 12 States that use this option are:

Connecticut	Minnesota	North Dakota
Hawaii	Missouri	Ohio
Illinois	New Hampshire	Oklahoma
Indiana	North Carolina	Virginia

An amendment included in the 1986 SSI disability amendments (P.L. 99-643) required, effective July 1, 1987, that 209(b) States continue Medicaid coverage for individuals in section 1619 status

if they had been eligible for Medicaid for the month preceding their becoming eligible under section 1619.

The same legislation required States to provide for continued Medicaid coverage for those individuals who lose their eligibility for SSI on or after July 1, 1987 when their income increases because they become newly eligible for Social Security benefits as an adult who became disabled as a child (disabled adult child) or because of an increase in their benefits as an adult who became disabled as a child. "Disabled adult children" who otherwise would be eligible for SSI continue to be considered SSI recipients for Medicaid purposes. Protection against loss of Medicaid also is provided for certain blind or disabled individuals who lose their SSI benefits when they qualify for Social Security disabled widow or widower's benefits beginning as early as age 50. The Omnibus Budget Reconciliation Act of 1990 provides that such individuals, who otherwise would continue to qualify for SSI on the basis of blindness or disability, will be deemed to be SSI recipients for purposes of Medicaid eligibility until they become eligible for Medicare Hospital Insurance. This provision has been effective since January 1, 1991.

ELIGIBILITY OF SSI RECIPIENTS FOR FOOD STAMPS

Except in California, which has converted food stamp benefits to cash that is included in the State supplementary payments, SSI recipients may be eligible to receive food stamps. SSI beneficiaries living alone or in a household where all other members of the household receive or are applying for SSI benefits can file for food stamps at an SSA office. If all household members receive SSI, they do not need to meet the food stamp program financial eligibility standards to participate in the program because they are categorically eligible. However, SSI beneficiaries living in households where other household members do not receive or are not applying for SSI benefits are referred to the local food stamp office to file for food stamps. These households must meet the net income eligibility standard of the food stamp program to be eligible for food stamp benefits.

The interaction with the food stamp program has important financial implications for a State which desires to increase the income of its SSI recipients by \$1. Because food stamps are reduced by \$0.30 for each additional \$1 of SSI income including State supplements, the State must expend \$1.43 to obtain an effective \$1 increase in SSI recipients' total income.

INCOME EXCLUSIONS

Under the program, \$20 of monthly income from virtually any source (such as Social Security benefits, but *not* need-tested income such as veterans' pensions) is excluded from countable income (total income minus exclusions). In addition, the first \$65 of monthly earned income plus one-half of remaining earnings are excluded. Income received in sheltered workshops and work activity centers is considered earned income and qualifies for earned income exclusions. Table 6-2 shows the maximum income that an individual and couple can have and still remain eligible for Federal SSI bene-

fits under the regular Federal SSI benefit standards—taking into account these income exclusions.

Work-related expenses are disregarded in the case of blind applicants or recipients and impairment-related work expenses are disregarded in the case of disabled applicants or recipients.

The SSI program also does not count income and/or resources that are set aside as part of an approved plan to achieve self-support (PASS). A PASS is an income and/or resource exclusion that allows a person who is blind or disabled to set aside income and/or resources for a work goal. The money set aside can be used to pay for such items or services as education, vocational training, or starting a business.

SSI law requires that an SSI applicant or recipient apply for all other benefits for which they are eligible. For example, in September 1993, 65 percent of the aged, 32 percent of the disabled, and 37 percent of the blind receiving SSI were also Social Security recipients.

The value of any in-kind assistance is counted as income unless such in-kind assistance is specifically excluded by statute. Generally, in-kind assistance provided by or under the auspices of a federally assisted program, or by a State or local government (for example, nutrition, food stamps, housing or social services), will not be counted as income. As described later, if an SSI applicant or recipient is living in the household of another and receiving in-kind support and maintenance from him or her, the SSI benefit standard for such an individual will be reduced by one-third of the Federal SSI benefit standard. By regulation, the Social Security Administration has also provided that the value of any in-kind support and maintenance received (other than in the case of those receiving in-kind assistance by reason of living in another's household), is presumed to be equal to one-third of the Federal SSI benefit standard plus \$20. The individual can rebut this presumption. If it is determined that the actual value is less than the one-third amount, the lower actual value will be counted as unearned income.

In-kind support and maintenance provided by a private nonprofit organization to aged, blind, or disabled individuals is excluded under the SSI program if the State determines that the assistance is provided on the basis of need. Another exclusion from income is certain types of assistance provided to help meet home energy needs. Assistance provided to an aged, blind, or disabled individual for the purpose of meeting home energy costs either in cash or in kind and which is furnished by a home heating oil or gas supplier or by a utility company is to be excluded. Assistance for home energy costs provided in-kind by a private nonprofit organization is also excluded.

As countable income increases, a recipient's SSI benefit amount decreases. Ineligibility for SSI occurs when countable income equals the Federal benefit standard plus the amount of applicable federally administered State supplementation.

TABLE 6-2.—MAXIMUM INCOME FOR ELIGIBILITY FOR FEDERAL SSI BENEFITS, 1994

	Receiving only Social Security		Receiving only wage income	
	Monthly	Annually	Monthly	Annually
Individual	\$466	\$5,592	\$977	\$11,724
Couple	689	8,268	1,423	17,076

Source: Supplemental Security Income, Social Security Administration.

RESOURCES

SSI eligibility is restricted to qualified persons who have countable resources not exceeding \$2,000, or \$3,000 in the case of married couples. The Deficit Reduction Act of 1984 (P.L. 98-369) increased the countable assets limit by \$100 a year for an individual and \$150 a year for a couple, beginning in calendar year 1985 and each year through calendar year 1989. Prior to January 1, 1985, the assets limit for an individual was \$1,500 and \$2,250 for a couple.

In determining countable resources, a number of items are not included, such as the individual's home; and, within reasonable limits set by the Secretary of Health and Human Services: household goods, personal effects, an automobile, and a burial space for the individual, spouse, and members of the immediate family. Regulations place a limit of \$2,000 in equity value on excluded household goods and personal effects and exclude the first \$4,500 in current market value of an auto (100 percent of the auto's value if it is used to obtain medical treatment or for employment or has been modified for use by or transportation of a handicapped person or is necessary to perform essential daily activities because of distance, climate or terrain). The value of property which is used in a person's trade, or business, or by the person as an employee is also excluded. The value of certain other property that produces income, goods or services essential to a person's self-support may be excluded within limits set by the Secretary in regulations. SSI and Social Security retroactive benefit payments may not be considered as a resource for a period of 6 months after the month in which the retroactive benefit is received. Resources set aside under a PASS are also excluded.

The cash surrender value of life insurance policies if the total face value of all policies on an individual's life is \$1,500 or less are not counted toward the \$2,000 or \$3,000 countable resources limit. The entire cash surrender value of life insurance policies if the total face value of all policies on an individual's life is greater than \$1,500 counts toward the resources limit, but may be excludable under one of the other resource provisions.

An individual and spouse may have excluded up to \$1,500 each of burial funds. However, the \$1,500 maximum amount is reduced by the face value of any excluded life insurance policies and the value of any irrevocable burial contracts, trusts or arrangements. If left to accumulate, interest earned on excluded burial funds and burial spaces is not countable as either income or resources for SSI purposes.

Current law provides that as of July 1, 1988, an individual who gives away or sells any nonexcludable resource for less than fair market value will no longer be subject to a penalty for such a transfer. However, such a transfer may make the individual ineligible for certain Medicaid covered nursing services. SSA must notify individuals of the penalty and provide information upon request to the States regarding transfers of resources.

The Deficit Reduction Act of 1984 (P.L. 98-369) requires the Internal Revenue Service to furnish the Social Security Administration with certain nonwage information about SSI recipients. The IRS information consists primarily of reports of interest payments submitted to IRS by financial institutions but also includes income from dividends, unemployment compensation, etc. The purpose of the provision was to assist in alerting the Social Security Administration of the potential ownership by SSI recipients of bank accounts in excess of the SSI countable resources limit. In fiscal year 1987, computer matches between IRS tax files and SSI records resulted in 239,000 such matches. Only cases involving IRS reports of interest income of \$51 or more were examined. The resulting savings to the SSI program were \$64 million. As a result of the Social Security Administration's evaluation of these cases, the tolerance level was lowered to \$41 beginning with fiscal year 1988 and 398,000 matches were identified. In fiscal year 1989, the matches totaled 508,000. SSA has evaluated and adjusted the tolerance levels several times over the years. Effective October 1993, the tolerance level for income from resources—e.g., interest and dividends—is \$60. The tolerance level for other nonwage income not from resources—e.g., unemployment compensation and pensions—is \$1,000. Also, a special tolerance was developed for cases that had been matched before; if the current year's resources are less than \$10 more than the prior year's resource indicators, the IRS report is not examined. All match information is sent to Social Security offices for verification of the information. For fiscal year 1993 there were about 413,000 matches. (The results of a study which will include an estimate of savings for the 1993 matches is not expected until the summer of 1994.)

Prior to the 1984 Deficit Reduction Act, if in any month a recipient's assets exceeded the asset limit, the individual was ineligible for benefits in that month and the entire amount of the benefit paid for that month was considered an overpayment subject to recovery. Effective 1984, SSI law provides that in cases where there is an overpayment based on an excess of assets of \$50 or less, the recipient is deemed to be without fault for purposes of waiving the overpayment and the overpayment is not recovered unless the Secretary finds that the failure to report the excess was knowing and willful on the part of the recipient.

An individual may receive SSI benefits for a limited time even though he has certain nonliquid property that, if counted, would make him ineligible. These benefits are conditioned upon the disposal of the property, and are subject to recovery as overpayments when the property is sold. The 1987 Budget Reconciliation Act provides, in addition, for the exclusion of real property, for so long as it cannot be sold, because it is jointly owned and sale would cause undue hardship to the joint owner due to loss of housing; has legal

impediments to its sale; or where reasonable efforts to sell it have been unsuccessful.

SSI BENEFITS

Individuals and couples applying for or receiving SSI benefits are determined to be eligible or to remain eligible if their countable income does not exceed certain levels, and they meet all other eligibility requirements.

Federal SSI benefit standard

The Federal SSI benefit standard for an individual for 1994 is \$446 a month and \$669 for a couple. As is discussed later, most States supplement the Federal SSI benefit. The result is a combined Federal SSI/State supplemented benefit against which countable income is compared in determining eligibility and benefit amount. However, many States limit their supplementation to certain categories of individuals based on specific indicators of need—especially special housing needs. In December 1993, 348,335 persons, or 5.8 percent of all SSI recipients, were eligible for benefits only because (federally-administered) State supplementation increased the benefit.

The Federal SSI benefits are indexed to the Consumer Price Index (CPI) and by the same percentage as Social Security benefits. This occurs through a reference in the SSI law to the Social Security cost-of-living adjustment (COLA) provision. Prior to the Social Security Amendments of 1983 (Public Law 98-21), the SSI and Social Security cost-of-living increases occurred in benefits paid in July. Public Law 98-21 delayed the Social Security and SSI COLA's from July 1983 to January 1984. However, in lieu of a COLA increase in the SSI benefit standard in July 1983, the Federal SSI benefit was increased in July, 1983, by \$20 a month for an individual and \$30 a month for a couple. Table 6-3 shows the Federal SSI benefit from the beginning of the SSI program until the present time.

Living in the household of another

The SSI law provides that if an SSI applicant or recipient is "living in another person's household and receiving support and maintenance in-kind from such person," the Federal SSI benefit applicable to such individual or couple is two-thirds of the regular Federal SSI benefit. As shown in table 6-3, the Federal SSI benefit in 1994 for those determined to be living in the household of another is \$297.34 for an individual and \$446 for a couple.

TABLE 6-3.—FEDERAL SSI BENEFIT LEVELS

[In dollars]

Date	Medic- aid in- stitu- tion	Eligibility status					
		Own household			Household of another		
		Single	Couple	Essential person	Single	Couple	Essential person
Initial	25.00	130.00	195.00	65.00	86.67	130.00	43.34
Jan. 1974	25.00	140.00	210.00	70.00	93.34	140.00	46.67
July 1974	25.00	146.00	219.00	73.00	97.34	146.00	48.67
July 1975	25.00	157.70	236.60	78.90	105.14	157.74	52.60
July 1976	25.00	167.80	251.80	84.00	111.87	167.87	56.00
July 1977	25.00	177.80	266.70	89.00	118.54	177.80	59.34
July 1978	25.00	189.40	284.10	94.80	126.27	189.40	63.20
July 1979	25.00	208.20	312.30	104.20	138.80	208.20	69.47
July 1980	25.00	238.00	357.00	119.20	158.67	238.00	79.47
July 1981	25.00	264.70	397.00	132.60	176.47	264.67	88.40
July 1982	25.00	284.30	426.40	142.50	189.54	284.27	95.00
July 1983	25.00	304.30	456.40	152.50	202.87	304.27	101.67
Jan. 1984 ¹	25.00	314.00	472.00	157.00	209.34	314.67	104.67
Jan. 1985	25.00	325.00	488.00	163.00	216.67	325.34	108.67
Jan. 1986	25.00	336.00	504.00	168.00	224.00	336.00	112.00
Jan. 1987	25.00	340.00	510.00	170.00	226.67	340.00	113.34
Jan. 1988	25.00	354.00	532.00	177.00	236.00	354.67	118.00
Jan. 1989	30.00	368.00	553.00	184.00	245.34	368.67	122.67
Jan. 1990	30.00	386.00	579.00	193.00	257.34	386.00	128.67
Jan. 1991	30.00	407.00	610.00	204.00	271.34	406.67	136.00
Jan. 1992	30.00	422.00	633.00	211.00	281.34	422.00	140.67
Jan. 1993	30.00	434.00	652.00	217.00	289.34	434.67	144.67
Jan. 1994	30.00	446.00	669.00	223.00	297.34	446.00	148.67

¹ Cost-of-living adjustments to Federal SSI benefit levels are rounded to the next lower whole dollar beginning with the increase effective January 1984.

Source: Office of Research and Statistics, Social Security Administration.

Regulations specify the criteria for determining when this reduced benefit applies. It does not apply to an individual who owns or rents; buys food separately; eats meals out rather than eating with the household; or pays a pro rata share of the household's food and shelter expenses.

In September 1993, 5.3 percent, or about 313,100 SSI recipients, had their benefits determined on the basis of this "one-third reduction" benefit standard. Sixty-five percent of those recipients were receiving benefits on the basis of disability (see table 6-4).

Of the 26 States and the District of Columbia that provide optional supplements to the Federal SSI benefit, 9 States and the District of Columbia provide the same amount of supplementation for those whose Federal SSI benefit amount is determined on the basis of the "one-third reduction." Eight States provide a higher State supplementation for such recipients; in six States the amount of State supplementation is less; two States provide no supplementation for those recipients; and one State's supplementation varies depending upon need.

Medicaid institution/personal needs allowance

When an individual enters a hospital or other medical institution in which more than half of the bill is paid by the Medicaid program, his or her monthly SSI benefit standard is reduced to \$30, beginning with the first full calendar month the individual is in such institution. This Personal Needs Allowance (PNA) is intended to take care of small personal expenses, with the cost of maintenance and medical care being provided through Medicaid. The Federal PNA benefit of \$25 was increased to \$30 a month on July 1, 1988—the first increase since the SSI program began in 1974. The annual cost-of-living increase for SSI does not apply to the personal needs allowance. The 1987 Budget Reconciliation Act does, however, provide that if a physician certifies that a person's stay in such a medical institution is not likely to exceed 3 months and the person needs to continue to maintain a home to which he or she may return, the SSI benefits will not be reduced and he or she will continue to receive the full SSI benefit for up to the first 3 months of institutionalization.

Approximately 165,400 or 2.8 percent of SSI recipients received benefits in September, 1993, on the basis of this personal needs allowance. For those individuals whose income from non-SSI sources exceeds the \$30 benefit standard (including those who previously, when they were not living in a medical institution, were receiving some SSI because their Social Security benefits were less than the regular SSI benefit), Medicaid regulations require States to allow such individuals (and other non-SSI Medicaid eligibles) to retain no less than \$30 a month of their income as a "personal needs allowance" when their income is applied, along with Medicaid reimbursement, to pay for their institutional medical care.

Sixteen State programs have exercised their option to supplement this Federal SSI benefit. Prior to the 1985 Budget Reconciliation Act, SSI regulations would not allow for Federal administration of the State supplements of these payments. An amendment included in that legislation now requires the Social Security Administration, at the request of a State, to administer such State supplementary payments. As of December 1993, California, the District of Columbia, Maine, Massachusetts, Michigan, New Jersey, New York, Rhode Island, and Vermont had opted for Federal administration. Approximately 24 States allow some or all of those individuals affected by the Medicaid personal needs allowance regulations to retain more than \$30 a month.

Another benefit affecting some persons involves Federal payments to an individual who was transferred to SSI from a former State program of aid to the aged, blind or disabled. The Federal benefits of these persons are increased by up to \$223 monthly in 1994 to take into account an "essential person" living in the household. An essential person is generally an ineligible spouse or relative whose needs were considered in determining the requirements of an eligible individual under the former State program but who is not eligible for SSI. Some States have categories of State supplementation similar to the "essential persons" category for individuals transferred from the pre-SSI program.

TABLE 6-4.—NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY REASON FOR ELIGIBILITY AND FEDERAL SSI BENEFIT STANDARD/LIVING ARRANGEMENT, SEPTEMBER 1993

Federal benefit standard/living arrangement ¹	Total	Reason for eligibility		
		Aged	Blind	Disabled
Total number	5,907,605	1,473,531	85,885	4,348,189
Total percent	100.0	100.0	100.0	100.0
Federal SSI benefit standard	91.9	90.5	91.4	92.4
Living in the household-of-another Federal SSI benefit standard	5.3	7.0	5.6	4.7
Medicaid institution/personal needs allowance Federal SSI benefit standard	2.8	2.6	3.0	2.8

¹ As used for determination of Federal SSI payment standard.

Source: Office of Research and Statistics, Social Security Administration.

DEEMING OF INCOME AND RESOURCES

The income of an ineligible spouse who lives with an adult SSI applicant or recipient is considered in determining the eligibility and amount of payment to the individual. The income of the parents of a child under the age of 18 who is blind or disabled is also considered in determining the eligibility and payment for the child. However, effective June 1, 1990, children with disabilities who are eligible for Medicaid at home under State home care plans, who previously received SSI personal needs allowances while in medical institutions, and who otherwise would be ineligible for SSI because of their parents' income or resources, can receive the \$30 monthly personal needs allowance that would be payable if they were institutionalized, without regard to their parents' income and resources. The law also provides that deeming of income and resources shall occur "except to the extent determined by the Secretary to be inequitable under the circumstances".

By regulation, the Secretary of HHS has provided that in determining the amount of the income of the ineligible spouse or parent to be deemed to the SSI applicant or recipient, the needs of the spouse or parent and other children in the household are taken into account. In addition, the SSI earned and unearned income exclusions are applied in determining the amount of income to be deemed to the SSI applicant or recipient. If the combined countable income of an SSI applicant and an ineligible spouse does not exceed the SSI benefit standard for an eligible couple in that State (including any federally-administered State supplementary payment), the SSI applicant would be eligible to receive an SSI and/or State supplementary benefit.

For example, in a State with no State supplementation the deeming procedure would work as follows in the case of an ineligible spouse earning \$520 per month living with an eligible individual with \$200 of Social Security benefits:

Unearned income of eligible individual	\$200.00
Less \$20 exclusion	- 20.00
Countable unearned income	180.00
Earned income of ineligible individual	520.00
Less \$65 earned income disregard	- 65.00
Less one-half of remaining earnings (\$455)	- 227.50
Countable earned income	227.50
Plus countable unearned income	180.00
Couple's total countable income	407.50
SSI payment standard for couples	669.00
Less countable income	- 407.50
Benefit payable to eligible individual	261.50

Thus the benefit for the eligible individual will be \$261.50. Without deeming, the individual would have received \$266 [\$446 - (\$200 less \$20 exclusion)]. The \$20 exclusion can only be used once and is first applied to unearned income, which in this example is the \$200 of Social Security income.

An individual's resources are deemed to include those of the ineligible spouse (or in the case of a child under the age of 18, those of the parents) with whom the individual is living. Under the Secretary's regulations, in determining the amount of the spouse's or parents' resources that can be deemed, all applicable exclusions are applied. In the case of a child, only the value of the parents' resources that exceeds the applicable limits (\$2,000 for a single parent, and \$3,000 for two parents) is deemed to the child.

In a study conducted in December 1989, there were about 92,700 cases in which deeming reduced benefits. Some 71,180 were spouse-to-spouse and 21,520 were parent-to-child cases. This does not take into account, however, the number of individuals who were not eligible because of the deeming provision.

In determining the eligibility of aliens applying for SSI, the income and resources of their sponsors are considered. After income and resources allowances for the needs of the sponsors and income allowances for their dependents, the remainder is deemed available for the support of the alien applicant. Prior to January 1, 1994, the remainder was deemed available for a 3-year period after the alien's entry into the United States. Effective January 1, 1994, through September 30, 1996, the remainder is deemed available for a 5-year period after the alien's entry into the United States. Under current law, the deeming period will revert to 3 years again on October 1, 1996. This provision does not apply to those who become blind or disabled after admission as a permanent resident, to refugees, and to persons granted political asylum.

OVERPAYMENTS

A provision in the 1984 Deficit Reduction Act established a limit on the rate that overpayments made to SSI recipients can be recovered. SSI law limits the amount of adjustment or recovery in any

month to the lesser of: (1) the amount of the benefit for that month; or (2) an amount equal to 10 percent of the countable income (plus the SSI payment) of the individual (or couple) for that month. This limitation does not apply if there is fraud in connection with the overpayment. The recipient may request a different rate at which benefits may be withheld to recover the overpayment.

STATE SUPPLEMENTATION

State supplementary payments are required by law to maintain income levels of former public assistance recipients transferred to the Federal SSI program. In February 1994, approximately 3,400 recipients or less than 0.1 percent of all recipients were receiving payments based in part or solely because of this provision. States have the option to choose to supplement the Federal SSI benefit standard for both former public assistance recipients and other SSI recipients. At the present time, all but eight States and jurisdictions provide some form of optional State supplementation. Those are: Arkansas, Georgia, Kansas, Mississippi, Commonwealth of the Northern Mariana Islands, Tennessee, Texas, and West Virginia. States (or local jurisdictions) may elect to administer their supplementary payments themselves or may contract with the Social Security Administration for Federal administration. Seventeen States and the District of Columbia have contracted with the Social Security Administration to administer the State optional supplementation program. Since the SSI program began in 1974, six States have shifted from Federal to State administration of their optional State supplementation program.

Administrative fees

The Omnibus Budget Reconciliation Act of 1993 amended the State supplementation provision to provide for State payment for Federal administration of State supplementary payments. For fiscal year 1994 (i.e., from October 1, 1993 through September 30, 1994), a State with federally administered supplementary payments pays the Secretary an administration fee of \$1.67 per payment. The rate per payment changes to \$3.33 for fiscal year 1995, and \$5.00 for fiscal year 1996 and each succeeding year, or a different rate deemed appropriate for the State by the Secretary.

State SSI supplement levels over time

Throughout the entire period from July, 1975, to January, 1994, 23 States have continuously provided supplemental SSI payments to aged individuals living independently, and 21 States continuously supplemented SSI payments to aged couples living independently.

During the period of July, 1975, to January, 1994, no State increased supplements faster than inflation for aged individuals living independently (see table 6-5).

The District of Columbia, South Dakota, Utah, and Wyoming all began supplementing SSI payments to individuals between 1975 and 1980.

Among the States which have supplemented SSI payments for aged couples living independently, only Alaska and Minnesota have kept their supplemental increases equivalent to or higher than in-

flation (see table 6-6). Other States have allowed inflation to erode the purchasing power of supplements or have reduced them in the face of State fiscal problems.

Approximately 44 percent of SSI recipients receive a State supplement. For those SSI recipients, other than those receiving a State supplement because they are living in some type of group living arrangement, the amount of State supplement ranges from \$1 a month to \$374 a month for an individual. At present, 26 States and the District of Columbia supplement the Federal standard for individuals living independently.

TABLE 6-5.—STATE SSI SUPPLEMENTS FOR AGED INDIVIDUALS WITHOUT COUNTABLE INCOME LIVING INDEPENDENTLY¹

State	July 1975	July 1980	Jan. 1985	Jan. 1988	Jan. 1990	Jan. 1991	Jan. 1992	Jan. 1993	Jan. 1994	Percent change (constant dollars) 1975-94 ¹
Alaska ²	\$142	\$235	\$261	\$305	\$331	\$349	\$362	\$374	\$374	-2
California	101	164	179	221	244	223	223	186	157	-42
Colorado	27	55	58	58	58	45	56	56	56	-23
Connecticut ³ ...	NA	NA	NA	393	366	359	325	³ NA	NA	NA
District of Co- lumbia	0	15	15	15	15	15	15	15	15	NA
Hawaii	17	15	5	5	5	5	5	5	5	-89
Idaho	63	74	78	73	73	70	70	65	45	-74
Illinois ³	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maine	10	10	10	10	10	10	10	10	10	-63
Massachusetts	111	137	129	129	129	129	129	129	129	-57
Michigan	12	24	27	30	30	31	14	14	14	-57
Minnesota ⁴	31	34	35	35	75	81	81	81	81	-3
Nebraska	67	75	61	43	38	24	30	28	28	-85
Nevada	55	47	36	36	36	36	36	36	36	-76
New Hampshire	12	46	27	27	27	27	27	27	27	-17
New Jersey	24	23	31	31	31	31	31	31	31	-52
New York	61	63	61	72	86	86	86	86	86	-48
Oklahoma	27	79	60	64	64	64	64	60	60	-18
Oregon	17	12	2	2	2	2	2	2	2	-96
Pennsylvania ...	20	32	32	32	32	32	32	32	32	-41
Rhode Island ...	31	42	54	59	64	64	67	64	64	-24
South Dakota ..	0	15	15	15	15	15	15	15	15	NA
Utah	0	10	10	9	6	6	5	5	1	NA
Vermont	29	41	53	58	63	65	65	57	55	-30
Washington ⁵ ...	36	43	38	28	28	28	28	28	28	-71
Wisconsin	70	100	100	103	103	103	92	93	85	-55
Wyoming	0	20	20	20	20	20	20	10	10	NA
Median	31	43	36	36	37	36	32	31	31	-63

¹ The percentage change in constant dollars was computed by inflating July 1975 to January 1994 by the CPI-U price index. The July 1975 index value is 54.2 and the January 1994 value is 146.2.

² 1975 and 1980—less if shelter costs less than \$35 monthly.

³ State decides benefit on a case-by-case basis.

⁴ State has two geographic payment levels—Hennepin County and the remainder of Minnesota. Level shown is for Hennepin County, the area with the largest number of SSI recipients.

⁵ State has two geographic payment levels—highest levels are shown in table. Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Office of Supplemental Security Income, Social Security Administration, and Committee on Ways and Means staff calculations.

TABLE 6-6.—STATE SSI SUPPLEMENTS FOR AGED COUPLES WITHOUT COUNTABLE INCOME LIVING INDEPENDENTLY

State	July 1975	July 1980	Jan. 1985	Jan. 1988	Jan. 1990	Jan. 1991	Jan. 1992	Jan. 1993	Jan. 1994	Percent change (constant dollars) 1975-94 ¹
Alabama	\$9	0	0	0	0	0	0	0	0	-100
Alaska ²	183	\$338	\$371	\$444	\$484	\$510	\$528	\$544	\$544	+10
California	251	389	448	534	588	557	557	488	440	-35
Colorado	133	229	278	292	309	293	323	328	323	-10
Connecticut ³ ...	NA	NA	NA	602	525	522	461	³ NA	NA	NA
District of Co- lumbia	0	30	30	30	30	30	30	30	30	NA
Hawaii	28	24	9	9	9	9	9	9	9	-88
Idaho	49	80	46	44	45	44	45	40	21	-84
Illinois ³	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maine	15	15	15	15	15	15	15	15	15	-63
Massachusetts	173	214	202	202	202	202	202	202	202	-57
Michigan	18	36	40	45	45	46	21	21	21	-57
Minnesota ⁴	38	44	66	66	88	132	129	126	126	+23
Nebraska	67	114	89	66	65	34	48	39	39	-78
Nevada	106	90	74	74	74	74	74	74	74	-74
New Hampshire	0	42	21	21	21	21	21	21	21	NA
New Jersey	13	12	25	25	25	25	25	25	25	-29
New York	76	79	76	93	102	103	103	102	102	-50
Oklahoma	54	158	120	128	128	128	128	120	102	-18
Oregon	17	10	0	0	0	0	0	0	0	-100
Pennsylvania ...	30	49	49	49	49	49	49	49	49	-39
Rhode Island ...	59	79	102	111	120	121	127	120	120	-25
South Dakota ..	0	15	15	15	15	15	15	15	15	NA
Utah	0	20	20	18	12	12	11	10	5	NA
Vermont	61	76	96	106	115	118	118	110	103	-37
Washington ⁵ ...	40	44	37	22	22	22	22	22	22	-80
Wisconsin	105	161	161	166	166	166	146	146	134	-53
Wyoming	0	40	40	40	40	40	40	19	19	NA
Median	57	63	66	66	65	49	49	30	39	-75

¹ The percentage change in constant dollars was computed by inflating July 1975 to January 1994 by the CPI-U price index. The July 1975 index value is 54.2 and the January 1994 value is 146.2.

² 1975 and 1980—less if shelter costs less than \$35 monthly.

³ State decides benefit on a case-by-case basis.

⁴ State has various geographic payment levels. Level shown is for Hennepin County, the area with the largest number of SSI recipients.

⁵ State has two geographic payment levels—highest levels are shown in table. Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Office of Supplemental Security Income, Social Security Administration.

MAXIMUM SSI AND FOOD STAMP BENEFITS FOR INDIVIDUALS LIVING INDEPENDENTLY

Table 6-7 for individuals living independently and table 6-8 for couples illustrate the maximum potential payment from Federal SSI, State supplements and food stamps for persons with no income, by State. These tables assume that the elderly individual or couple receive an excess shelter deduction of \$207 (the maximum for nonelderly) and an excess medical cost deduction of \$13 in the food stamp program. Approximately 64 percent of the elderly in the food stamp program take a shelter deduction, and it is estimated that approximately 17 percent of the elderly are allowed a deduction that exceeds the excess shelter expense ceiling for nonelderly or nondisabled households (\$207 per month). However, since only 13 percent of the elderly claim a medical cost deduction, the \$13 average of medical cost deductions averaged over all elderly recipients was chosen. Since only 17 percent of all elderly claimed more than the shelter cost deduction ceiling, the shelter deduction ceiling was chosen.

TABLE 6-7.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED INDIVIDUALS LIVING INDEPENDENTLY, JANUARY 1994 ¹

State	Maximum SSI benefit	Food stamp benefit ²	Combined benefits	
			Monthly	Annual
Alabama	\$446	\$83	\$529	\$6,348
Alaska	820	79	899	10,788
Arizona	446	83	529	6,348
Arkansas	446	83	529	6,348
California	603	³ 0	603	7,236
Colorado	502	66	568	6,816
Connecticut	⁴ NA	NA	NA	NA
Delaware	446	83	529	6,348
District of Columbia	461	79	540	6,480
Florida	446	83	529	6,348
Georgia	446	83	529	6,348
Hawaii	451	187	638	7,656
Idaho	⁵ 491	76	567	6,804
Illinois	⁶ NA	NA	NA	NA
Indiana	446	83	529	6,348
Iowa	446	83	529	6,348
Kansas	446	83	529	6,348
Kentucky	446	83	529	6,348
Louisiana	446	83	529	6,348
Maine	456	80	536	6,432
Maryland	446	83	529	6,348
Massachusetts	575	44	619	7,428
Michigan	460	79	539	6,468
Minnesota	⁷ 527	59	586	7,032
Mississippi	446	83	529	6,348
Missouri	446	83	529	6,348
Montana	446	83	529	6,348

TABLE 6-7.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED INDIVIDUALS LIVING INDEPENDENTLY, JANUARY 1994 ¹—Continued

State	Maximum SSI benefit	Food stamp benefit ²	Combined benefits	
			Monthly	Annual
Nebraska	474	75	549	6,588
Nevada	482	72	554	6,648
New Hampshire	473	75	548	6,576
New Jersey	477	74	551	6,612
New Mexico	446	83	529	6,348
New York	532	57	589	7,068
North Carolina	446	83	529	6,348
North Dakota	446	83	529	6,348
Ohio	446	83	529	6,348
Oklahoma	506	65	571	6,852
Oregon	448	82	530	6,360
Pennsylvania	478	73	551	6,612
Rhode Island	510	64	574	6,888
South Carolina	446	83	529	6,348
South Dakota	461	79	540	6,480
Tennessee	446	83	529	6,348
Texas	446	83	529	6,348
Utah	447	83	530	6,360
Vermont	⁸ 501	67	568	6,816
Virginia	446	83	529	6,348
Washington	⁹ 474	75	549	6,588
West Virginia	446	83	529	6,348
Wisconsin	531	57	588	7,056
Wyoming	456	80	536	6,432

¹ In most States these maximums apply also to blind or disabled SSI recipients who are living in their own households; but some States provide different benefit schedules for each category.

² For one-person households, maximum food stamp benefits from Oct. 1993 through Sept. 1994 are \$112 in the 48 contiguous States and the District of Columbia, \$147 in Alaska (urban areas, benefit levels in rural Alaska are increased by about 50 percent to account for higher food prices in such areas), and \$187 in Hawaii.

For the 48 contiguous States and D.C., the calculation of benefits assumes: (1) a "standard" deduction of \$131 per month; (2) an excess shelter deduction of \$207 per month (the maximum allowable for nonelderly, nondisabled households); and (3) an excess medical expense deduction of \$13 monthly (estimated from 1991 medical expense information). If smaller excess shelter costs were assumed, food stamp benefits would be smaller. For Alaska and Hawaii, higher deduction levels were used, as provided by law (\$595 and \$493, respectively, for combined standard and excess shelter allowance).

³ SSI recipients in California are ineligible for food stamps. California provides increased cash aid in lieu of stamps.

⁴ Individual budget process.

⁵ State disregards \$20 of SSI payment in determining the State supplementary payment.

⁶ State decides benefits on case-by-case basis.

⁷ Payment level for Hennepin County. State has two geographic payment levels—one for Hennepin County and the other for the remainder of the State.

⁸ State has two geographic payment levels—highest are shown in table.

⁹ Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of data from the Social Security Administration.

TABLE 6-8.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED COUPLES LIVING INDEPENDENTLY, JANUARY 1994 ¹

State	Maximum SSI benefit	Food stamp benefit ²	Combined benefits	
			Monthly	Annual
Alabama	\$669	\$110	\$779	\$9,348
Alaska	1,213	85	1,298	15,576
Arizona	669	110	779	9,348
Arkansas	669	110	779	9,348
California	1,109	³ 0	1,109	13,308
Colorado	992	13	1,005	12,060
Connecticut	⁴ NA	NA	NA	NA
Delaware	669	110	779	9,348
District of Columbia	699	101	800	9,600
Florida	669	110	779	9,348
Georgia	669	110	779	9,348
Hawaii	678	287	965	11,580
Idaho	⁵ 690	110	800	9,600
Illinois	⁶ NA	NA	NA	NA
Indiana	669	110	779	9,348
Iowa	669	110	779	9,348
Kansas	669	110	779	9,348
Kentucky	669	110	779	9,348
Louisiana	669	110	779	9,348
Maine	684	106	790	9,480
Maryland	669	110	779	9,348
Massachusetts	871	50	921	11,052
Michigan	690	104	794	9,528
Minnesota	⁷ 795	72	867	10,404
Mississippi	669	110	779	9,348
Missouri	669	110	779	9,348
Montana	669	110	779	9,348
Nebraska	708	98	806	9,672
Nevada	743	88	831	9,972
New Hampshire	690	104	794	9,528
New Jersey	694	103	797	9,564
New Mexico	669	110	779	9,348
New York	771	79	850	10,200
North Carolina	669	110	779	9,348
North Dakota	669	110	779	9,348
Ohio	669	110	779	9,348
Oklahoma	789	74	863	10,356
Oregon	669	110	779	9,348
Pennsylvania	718	95	813	9,756
Rhode Island	789	74	863	10,356
South Carolina	669	110	779	9,348

TABLE 6-8.—MAXIMUM POTENTIAL SSI AND FOOD STAMP BENEFITS FOR AGED COUPLES LIVING INDEPENDENTLY, JANUARY 1994 ¹—Continued

State	Maximum SSI benefit	Food stamp benefit ²	Combined benefits	
			Monthly	Annual
South Dakota	684	106	790	9,480
Tennessee	669	110	779	9,348
Texas	669	110	779	9,348
Utah	674	109	783	9,396
Vermont	⁸ 772	79	851	10,212
Virginia	669	110	779	9,348
Washington	⁹ 691	103	794	9,528
West Virginia	669	110	779	9,348
Wisconsin	803	70	873	10,476
Wyoming	688	104	792	9,504

¹In most States these maximums apply also to blind or disabled SSI recipients who are living in their own households; but some States provide different benefit schedules for each category.

²For two-person households, maximum food stamp benefits from Oct. 1993 through Sept. 1994 are \$206 in the 48 contiguous States and the District of Columbia, \$271 in Alaska (urban areas, benefit levels for rural Alaska are about 50 percent higher to account for high food prices in such areas), and \$343 in Hawaii.

For the 48 contiguous States and D.C., the calculation of benefits assumes: (1) a "standard" deduction of \$131 per month, (2) an excess shelter deduction of \$207 per month (the maximum allowable for nonelderly, nondisabled households); and (3) an excess medical expense deduction of \$13 monthly (estimated from 1991 medical expense information). If smaller excess shelter costs were assumed, food stamp benefits would be smaller. For Alaska and Hawaii, higher deduction levels were used, as provided by law (\$595 and \$493, respectively, for combined standard and excess shelter allowance).

³SSI recipients in California are ineligible for food stamps. California provides increased cash aid in lieu of stamps.

⁴Individual budget process.

⁵State disregards \$20 monthly of SSI income in determining the State supplementary payment amounts.

⁶State decides benefits on case-by-case basis.

⁷Payment level for Hennepin County. State has two geographic payment levels—one for Hennepin County and one for the remainder of the State.

⁸State has two geographic payment levels—highest levels are shown in table.

⁹Sum paid in King, Pierce, Kitsap, Snohomish, and Thurston Counties.

Source: Table prepared by the Congressional Research Service (CRS) on the basis of data from the Social Security Administration.

State supplementation for special housing needs

A significant number of the aged, disabled and blind population receiving SSI cannot live alone because of mental or physical limitations and have a need for housing which involves services beyond room and board. These services often include supervision for daily living and protective services for the mentally retarded, chronically mentally ill, or the frail or confused elderly. Such nonmedical supervised and/or group living arrangements generally cost more than the Federal SSI benefit needs standard of \$446 a month and often more than the combined Federal and SSI State supplementation for those classified as living independently.

All but 10 of the 50 States and the District of Columbia have Federal or State administered State supplementation which is specifically directed at covering the additional cost of providing housing in a protective, supervised, or group living arrangement.

These living arrangements are identified by a variety of terms including: adult foster care homes; domiciliary care homes; congregate care; group homes for the mentally retarded and a variety of other terms. The amount of supplementation by the State also varies a great deal. For example, in the State of Maryland under a State-administered supplementation program, a "specialized and intensive supervision" group living facility has a State supplementation of \$702 a month in addition to the Federal benefit level of \$446. The total Federal and State SSI payment in a month is \$1,148. In one State the State supplementation is less than \$2 a month for those who need little supervision and care. However, in some States, the cost of supervised group living care is also partially met by direct State funding of the staff. In a number of States, the State makes payments for nonmedical group care directly to private residential facilities based on a rate negotiated by the State with each facility. In such cases, there is often a "personal needs allowance" payment made directly to or on behalf of the residents of the facility.

COMPARISON OF SSI PAYMENT LEVELS TO POVERTY THRESHOLDS

Table 6-9 compares the Federal SSI benefit for a single individual to the Bureau of the Census poverty threshold. Both the poverty threshold and the benefit level are indexed to the Consumer Price Index. (The percentage increase for the poverty threshold and the SSI benefit increase varies slightly because of a difference in the method of calculation.) As a result of Public Law 98-21, the SSI benefit levels were increased by \$20 per month for individuals and \$30 per month for couples in July 1983. They were further increased by 3.5 percent in January 1984. This explains why SSI benefits, in relation to the poverty level, increased to approximately 75 percent in 1984 and 1985 compared to 71 percent in the 1975 to 1982 period. In 1993, benefit levels were 75.2 percent of the poverty level.

Table 6-10 presents the same information for a couple. The SSI benefit for a couple is approximately 90 percent of the poverty threshold.

CHARACTERISTICS OF THE SSI POPULATION

As shown in table 6-12, in September 1993, 5.908 million persons received federally administered SSI payments. Of these, 1.474 million received federally administered payments on the basis of being aged, 4.348 million on the basis of being disabled, and 85,885 on the basis of blindness. However, approximately 636,391 of those receiving benefits on the basis of disability or blindness were over the age of 65. Table 6-12 also indicates that approximately 3.4 million of those receiving federally administered SSI payments only receive Federal SSI payments, 2.2 million receive a combination of federally financed and State financed payments, and 346,271 receive State financed supplementation only.

TABLE 6-9.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE INDIVIDUALS RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 TO 1994

	Calendar year—									
	1975	1980	1984	1986	1988	1990	1991	1992	1993	1994
Poverty threshold	2,572	3,941	4,980	5,255	5,672	6,268	6,532	6,729	6,930	17,117
Federal SSI benefits:										
Dollars per year	1,822	2,677	3,768	4,032	4,248	4,632	4,884	5,064	5,208	5,352
Percent of poverty	70.8	72.3	75.6	76.7	74.9	73.9	74.8	75.3	75.2	75.2
Federal SSI and Social Security:										
Dollars per year	2,062	2,917	4,008	4,272	4,488	4,872	5,124	5,304	5,448	5,592
Percent of poverty	80.2	74.0	80.5	81.3	79.1	77.7	78.4	78.8	78.6	78.6
Federal SSI, Social Security, and food stamps: ²										
Dollars per year	2,350	3,345	4,294	4,488	4,848	5,318	5,580	5,820	5,952	6,144
Percent of poverty	91.4	84.9	86.2	85.4	85.5	84.8	85.4	86.5	85.9	86.3

¹ Projected on basis of CBO projected increases in the consumer price index.

² In computing the food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standard deduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

TABLE 6-10.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE COUPLES RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 TO 1994

	Calendar year—									
	1975	1980	1984	1986	1988	1990	1991	1992	1993	1994
Poverty threshold	3,232	4,954	6,280	6,628	7,156	7,906	8,238	8,489	8,741	18,977
Federal SSI benefits:										
Dollars per year	2,734	4,016	5,664	6,048	6,384	6,948	7,320	7,596	7,824	8,028
Percent of poverty	84.6	81.1	90.2	91.2	89.2	87.9	88.9	89.5	89.5	89.4
Federal SSI and Social Security:										
Dollars per year	2,974	4,256	5,904	6,288	6,624	7,188	7,560	7,836	8,064	8,268
Percent of poverty	92.0	86.0	94.0	94.9	92.6	90.9	91.8	92.3	92.3	92.1
Federal SSI, Social Security, and food stamps: ²										
Dollars per year	3,430	4,906	6,393	6,696	7,200	7,935	8,340	8,700	8,880	9,084
Percent of poverty	106.1	99.0	101.8	101.0	100.6	100.4	101.2	102.5	101.6	101.2

¹ Projected on basis of CBO projected increases in the consumer price index.

² In computing the food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standard deduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

Table 6-13 shows the trends in the numbers of persons receiving federally administered SSI payments from December, 1975, through September, 1993, both by reason for eligibility and by age categories. There was a steady decline in the number of SSI recipients from 1975 until 1983. However, in the last 9 years the number of SSI recipients has increased from about 3.9 million to more than 5.9 million.

Characteristics of adult SSI recipients receiving benefits on the basis of disability or blindness

Major disabling diagnosis.—As shown in table 6-11, of the SSI disabled ages 18-64, 23.7 percent were eligible on the basis of mental retardation; and 32.2 percent on the basis of other mental disorders. Therefore, over one-half of all SSI disabled recipients are eligible on the basis of a mental disability. The next three largest categories are: diseases of the nervous system and sense organs—8.8 percent; diseases of musculoskeletal and connective tissues—8.7 percent; and diseases of the circulatory system—6.8 percent. Related to the nature of the impairments of the SSI disabled is the fact that in December 1993, 1,145,700 or 30.6 percent of the adult disabled or blind receiving SSI benefits had a representative payee. Representative payees are individuals, agencies or institutions selected by the Social Security Administration to receive and use SSI payments on behalf of the SSI recipient when it has been found necessary by reason of the mental or physical limitations of the recipient.

Age.—When a person who is receiving SSI on the basis of blindness or disability becomes age 65, the Social Security Administration does not convert the individual to eligibility on the basis of age. As shown in table 6-14, 17 percent of the SSI adult population receiving benefits on the basis of disability are age 65 or over (28.2 percent of the blind were age 65 or over).

Sex.—In January 1994, 55 percent of those receiving SSI benefits on the basis of disability and 56.4 percent on the basis of blindness were women (table 6-15).

Race.—In January 1994, 57.6 percent of those receiving SSI on the basis of disability were white; 31.2 percent were black; 7.9 percent were other races; and in 3.4 percent of the cases, race was not reported (table 6-15).

Other income.—In September 1993, 32.4 percent of the disabled and 36.9 percent of the blind received Social Security benefits. Table 6-16 shows the number of SSI recipients with other sources of unearned income.

Of the blind and disabled receiving SSI, 5.2 percent had earned income in September 1993 (table 6-16).

Characteristics of SSI recipients receiving benefits on the basis of age

Age.—In September 1993, as shown in table 6-14, of those SSI recipients receiving benefits on the basis of age, i.e., age 65 or older, 35.9 percent were 80 years of age or older.

Sex.—In January 1994, as shown in table 6-15, 73.8 percent of those receiving benefits on the basis of age were women.

Race.—As shown in table 6-15, 55.4 percent of those receiving SSI on the basis of age were white; 22.0 percent were black; 19.4 percent were other races; and in 3.1 percent of the cases, race was not reported.

Other income.—65.1 percent of the SSI recipients receiving benefits on the basis of age also received Social Security benefits. Only 2.1 percent had earned income.

Characteristics of children receiving SSI payments

In June 1993, 732,000 blind and disabled children were eligible for SSI payments. These children made up 12.6 percent of the over 5.8 million SSI recipients in June, and represent a fast growing segment of the SSI population. By comparison, in December 1980 payments were made to almost 229,000 blind and disabled children (5.5 percent of the 4.1 million recipients in that month).

To be eligible for SSI payments as a child, an individual must be under age 18 (or under 22 if he or she is a full time student), unmarried, and must meet the SSI disability or blindness, citizenship/residency, and income and resources criteria [applicable to adults].

In June 1993, almost 61 percent of the SSI children were 12 years old or less, and an estimated 20 percent of the children were under age 6. About 28 percent, an estimated 199,000 children were between the ages of 13 and 17. Child recipients are more likely to be boys than girls, by about three or two. Approximately 46 percent are nonwhite.

Three-quarters of the children live in their parents' home. Less than 2 percent are patients in a medical facility where more than half of the cost of their care is covered by the Medicaid program. Another 18 percent live in other hospitals, nursing homes, residential schools, foster care, or independently.

About 29 percent of the children had some type of unearned income. The three major types of unearned income were: in-kind support and maintenance (8.2 percent), Social Security benefits (8.1 percent), and support from absent parents (7.2 percent). In addition, about 10 percent of the children had income "deemed" from their parents.

More than half (61 percent) of the SSI children were medically eligible based on a mental disorder, and most of these (43 percent) were mentally retarded. The only other diagnostic category of any size was diseases of the nervous system and sense organs, which included all of the approximately 9,000 blind children on SSI in June 1993.

TABLE 6-11.—DISABILITY DIAGNOSIS OF SSI AND SECTION 1619 DISABILITY RECIPIENTS: JUNE 1993¹

[Percentage distribution by diagnostic group]

Diagnostic group	Supplemental Security Income—SSI		
	All SSI disabled 18-64 yrs. ¹	SSI sec. 1619(a) participants ²	SSI sec. 1619(b) participants ²
Individuals	2,614,310	18,597	34,293
Total percent	100.0	100.0	100.0
Infectious and parasitic diseases	1.9	0.9	1.5
Neoplasms	1.7	1.3	1.8
Endocrine, nutritional, and metabolic disorders	4.1	2.5	2.6
Mental disorders (other than mental retardation)	28.1	26.5	28.1
Mental retardation	28.2	43.7	35.8
Diseases of:			
Nervous system and sense organs ² ..	11.0	13.7	14.6
Circulatory system	6.1	2.0	2.7
Respiratory system	2.8	0.8	0.8
Digestive system	0.7	0.3	0.5
Musculoskeletal system	7.6	2.6	4.4
Congenital anomalies	1.7	0.9	0.7
Injuries	3.2	2.6	3.7
Other	2.9	2.2	2.8

¹ Information on diagnosis of SSI disabled recipients under age 65 is from the December 1992 SSI 10-percent disability file. Information on diagnosis for section 1619 recipients is available from SSI source files. Percentages shown are based on 12,786 section 1619(a) participants, and 22,749 section 1619(b) participants.

² Most of these section 1619(b) participants who are classified as blind individuals are included in this category. A few section 1619(b) blind participants have a primary impairment other than diseases of the eye and are coded in other categories in this table. Also, there are a few participants classified as having diseases of the eye who are not blind, whose impairment does not meet the definition of blindness, and are classified as disabled.

Source: Social Security Administration, OSSI.

TABLE 6-12.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, TOTAL AMOUNT AND AVERAGE MONTHLY AMOUNT, BY SOURCE OF PAYMENT AND CATEGORY, SEPTEMBER 1993

Source of payment	Total	Aged	Blind	Disabled
Number of persons				
With—				
Federally administered pay- ments ³	5,907,605	1,473,531	¹ 85,885	² 4,348,189
Federal payment only .	3,406,549	792,980	44,084	2,569,485
Both Federal and State supplementation	2,154,785	528,979	34,415	1,591,391
State supplementation only	346,271	151,572	7,386	187,313
Total with—				
Federal payment ⁴	5,561,334	1,321,959	78,499	4,160,876
State supplementation ⁵	2,501,056	680,551	41,801	1,778,704
Amount of payments [in thousands]				
Total	2,036,914	345,961	30,984	1,659,968
Federal payments	1,762,015	267,490	24,401	1,470,123
State supplementation	274,899	78,471	6,583	189,845
Average monthly amount				
Total	\$344.80	\$234.73	\$360.76	\$381.76
Federal payments	316.83	202.34	310.84	353.32
State supplementation	109.91	115.31	157.48	106.73

¹ Includes an estimated 21,609 persons age 65 or older.

² Includes an estimated 614,782 persons age 65 or older.

³ All persons with Federal SSI payments and/or federally administered State supplementation.

⁴ All persons with a Federal SSI payment whether receiving a Federal payment only or both a Federal and State supplementation.

⁵ All persons with federally administered State supplementation whether receiving State supplementation only or both a Federal SSI payment and a State supplementation.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 6-13.—SSI: NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, BY CATEGORY AND AGE: DECEMBER 1975, SEPTEMBER 1983, 1986, 1988, 1989, 1990, 1991, 1992, AND 1993

[In thousands]

Reason for eligibility and by age categories	Dec. 1975	Sept. 1983	Sept. 1986	Sept. 1988	Sept. 1989	Sept. 1990	Sept. 1991	Sept. 1992	Sept. 1993
Total	4,314	3,898	4,232	4,434	4,570	4,764	5,050	5,486	5,908
Reason for eligibility:									
Aged	2,307	1,528	1,476	1,434	1,439	1,452	1,463	1,478	1,474
Blind	74	79	83	83	83	84	85	86	86
Under 18	3	6	7	7	7	7	7	8	8
18 to 21	4	5	5	4	4	4	4	4	4
22 to 64	46	45	48	49	49	50	51	52	52
65 and over	22	23	23	22	22	22	22	22	22
Disabled	1,933	2,292	2,673	2,917	3,048	3,229	3,502	3,921	4,348
Under 18	104	191	231	247	256	287	366	511	683
18 to 21	90	122	138	136	139	143	150	167	186
22 to 64	1,559	1,517	1,787	1,987	2,091	2,218	2,393	2,637	2,864
65 or over	179	462	517	548	563	579	592	606	615
Age:									
Under 18	107	197	238	254	263	294	373	518	691
18 to 21	93	127	143	140	143	147	154	171	190
22 to 64	1,605	1,562	1,835	2,036	2,140	2,269	2,445	2,690	2,917
65 and over	2,508	2,013	2,016	2,003	2,023	2,051	2,078	2,107	2,110

Source: Office of Research and Statistics, Social Security Administration.

TABLE 6-14.—NUMBER AND PERCENTAGE DISTRIBUTION OF SSI RECIPIENTS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY CATEGORY AND AGE, SEPTEMBER 1993

Age	Total	Aged	Blind	Disabled
Children:				
Total number	737,150	.....	9,285	727,865
Total percent	100.0	.....	100.0	100.0
Under 5	16.4	.....	15.7	16.4
5 to 9	28.2	.....	27.2	28.3
10 to 14	32.7	.....	28.9	32.7
15 to 17	16.5	.....	15.9	16.5
18 to 21 ¹	6.2	.....	12.4	6.2
Adults:				
Total number	5,170,455	1,473,531	76,600	3,620,324
Total percent	100.0	100.0	100.0	100.0
18 to 21	2.8	.....	3.9	3.9
22 to 29	9.0	.....	13.4	12.6
30 to 39	13.9	.....	16.4	19.6
40 to 49	12.6	.....	14.7	17.7
50 to 59	13.4	.....	14.5	18.8
60 to 64	7.5	.....	8.8	10.5
65 to 69	11.3	21.0	8.5	7.4
70 to 74	10.1	24.1	6.4	4.5
75 to 79	7.6	19.0	5.0	3.1
80 or older	11.7	35.9	8.3	2.0

¹ Persons aged 18-21 can be classified as either children or adults depending on their student status.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 6-15.—NUMBER AND PERCENTAGE DISTRIBUTION OF ALL PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS, BY CATEGORY, RACE, AND SEX, JANUARY 1994

Race and sex	Total	Aged	Blind	Disabled
Total number	5,948,900	1,465,300	85,500	4,398,100
Total percent	100.0	100.0	100.0	100.0
Race:				
White	57.1	55.4	57.4	57.6
Black	28.9	22.0	26.8	31.2
Other	10.8	19.4	11.3	7.9
Not reported	3.3	3.1	4.4	3.4
Sex and race:				
Men	40.3	26.2	43.6	45.0
White	22.6	13.9	24.6	25.4
Black	11.7	4.8	11.9	14.0
Other	4.5	6.7	4.9	3.7
Not reported	1.6	.8	2.2	1.8
Women	59.6	73.8	56.4	55.0
White	34.5	41.5	32.9	32.2
Black	17.1	17.2	14.9	17.1
Other	6.3	12.7	6.4	4.2
Not reported	1.7	2.3	2.2	1.5

Source: Office of Research and Statistics, Social Security Administration.

In summary, the trends in the nature of the SSI population show the following:

- A steady decline in the number of persons receiving SSI benefits on the basis of old age.
- An increase from 107,000 in December 1975 to 737,150 in September 1993 of the number of disabled and blind children under 18 receiving SSI benefits.
- A sharp increase of 1,354,000 between 1983 and 1993 in the number of persons ages 22–64 receiving benefits on the basis of disability or blindness.

TABLE 6-16.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED PAYMENTS AND NUMBER WITH CONCURRENT INCOME AND AVERAGE MONTHLY AMOUNT, BY CATEGORY AND TYPE OF INCOME, SEPTEMBER 1993

Type of income	Total	Reason for eligibility		
		Aged	Blind	Disabled
Total number	5,907,605	1,473,531	85,885	4,348,189
Number				
Social Security benefits	2,402,028	959,733	31,673	1,410,622
Other unearned income	828,619	325,950	11,029	491,640
Earned income	262,236	30,589	6,175	225,472
Average monthly income				
Social Security benefits	\$330.48	\$336.21	\$345.30	\$326.25
Other unearned income	97.62	76.75	95.68	111.50
Earned income	213.59	200.52	520.31	206.96

Source: Office of Research and Statistics, Social Security Administration.

TABLE 6-17.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS AND UNEARNED INCOME (OTHER THAN SOCIAL SECURITY) AND AVERAGE MONTHLY UNEARNED INCOME, BY TYPE OF INCOME, SEPTEMBER 1993

Type of income	Number ¹	Average ²
Total	828,619	\$97.62
Veterans' benefits	121,647	149.74
Railroad retirement	5,225	307.54
Black lung benefits	1,766	293.99
Employment pensions	46,914	112.26
Worker's compensation	4,110	292.68
Support and maintenance in kind	212,242	99.86
Support from absent parents	56,849	148.57
Asset income	241,251	10.10
Assistance based on need	58,145	71.20
Other ³	80,470	221.96

¹ With unearned income other than social security benefits.² Monthly amount of unearned income.³ Includes military, civil service pension, and demonstration projects.

Source: Office of Research and Statistics, Social Security Administration.

SSI PARTICIPATION RATES

Table 6-18 shows Federal SSI participation among the elderly and the total population using various measures. The numerator in the first three columns is the sum of columns two and four in table 6-21. In other words, the number of SSI aged participants includes the disabled population over age 65. Column one simply divides the SSI aged participants by the total number of elderly. That rate declined from 11.1 percent in 1975 to 6.5 percent in 1992, primarily as a result of increasing incomes among the aged and decreasing participation among low-income elderly. Column two presents the number of elderly SSI recipients divided by the number of poor elderly. This rate has declined from 76 percent in 1975 to 54 percent in 1982. Between 1982 and 1984, this percentage increased, perhaps as a result of outreach efforts mandated by the 1983 Social Security Amendments (P.L. 98-21). After 1984, the rate declined to 56.5 percent in 1987, increased to 60.1 percent in 1989, and declined to 53 percent in 1992. This is a gross measure of participation, in that it does not control for other SSI eligibility factors, such as assets or the undercounting of income. Column three shows the number of SSI aged recipients as a percentage of the number of poor elderly before means-tested transfers.

The final column of table 6-18 shows the number of Federal SSI participants as a percentage of the total population. The numerator for this calculation is the first column of table 21. As shown in the table, the percentage of the entire population receiving SSI benefits has declined from 2.0 percent in 1975 to 1.7 percent for the 1982 to 1985 time period. It has since increased to 2.3 percent in 1993 and is projected to increase to 2.5 percent by 1994.

TABLE 6-18.—SSI PARTICIPATION RATES

[In percent]

	Among all elderly	Among elderly poor	Among pretransfer elderly poor	Among entire population
1975	11.1	75.6	NA	2.0
1976	10.3	72.4	NA	1.9
1977	9.8	74.1	NA	1.9
1978	9.4	71.5	NA	1.9
1979	9.0	61.3	68.7	1.8
1980	8.7	57.5	64.7	1.8
1981	8.1	55.0	63.3	1.8
1982	7.5	53.6	62.3	1.7
1983	7.3	55.2	61.9	1.7
1984	7.3	61.2	66.3	1.7
1985	7.1	58.7	64.5	1.7
1986	6.9	57.9	63.4	1.8
1987	6.8	56.5	64.7	1.8
1988	6.6	57.6	64.3	1.8
1989	6.5	60.1	64.6	1.9
1990	6.6	56.3	63.3	1.9
1991	6.8	55.0	61.1	2.0
1992	6.5	52.7	NA	2.2
1993 ¹	6.6	NA	NA	2.3
1994 ¹	6.7	NA	NA	2.5

¹ Projected.

NA—Not available.

Note.—The denominator for columns 1 and 4 is in table 15, appendix N, the denominator for column 3 is shown in table 3 of appendix J, and the denominator for column 3 is in table 19 of appendix J.

Source: Staff of the Committee on Ways and Means.

Table 6-19 shows the percentage of a given State's population receiving SSI benefits for selected years. Table 6-20 shows the percentages of a State's total, aged, and disabled populations between the ages of 18 and 64 receiving SSI benefits for both 1979 and 1993, respectively. The percentage of the population receiving SSI has been calculated by dividing the average number of monthly Federal SSI recipients in each State for each of the selected years by the State's population in July of those selected years. Likewise, percentages for the aged and disabled have been calculated by dividing a State's average number of monthly recipients in each program by that State's aged and disabled population in July 1979 and 1993.

As shown in table 6-19, the total percentage of the population receiving SSI benefits increased to 2.26 percent in 1993 from 2 percent in 1975. However, between these years, the percentage of the population receiving SSI benefits declined to 1.74 percent in 1985 (a 13 percent decline) and has since risen to 2.26 percent of the population in 1993.

As shown in table 6-20 the proportion of adult SSI recipients aged 18-64 in this total population rose from 1.26 to 1.90 percent.

TABLE 6-19.—SSI RECIPIENCY RATES BY STATE
[In percent]

State	1975	1985	1990	1991	1992	1993
Alabama	3.98	3.29	3.29	3.35	3.43	3.64
Alaska	0.81	0.65	0.84	0.87	0.90	0.96
Arizona	1.24	1.04	1.22	1.33	1.42	1.54
Arkansas	4.09	3.14	3.23	3.34	3.47	3.66
California	3.09	2.59	2.93	3.03	3.10	3.14
Colorado	1.37	0.93	1.14	1.23	1.29	1.38
Connecticut	0.76	0.83	0.98	1.05	1.10	1.19
Delaware	1.19	1.21	1.21	1.23	1.27	1.34
District of Columbia	2.23	2.51	2.67	2.83	3.00	3.21
Florida	1.86	1.62	1.71	1.82	1.90	2.06
Georgia	3.27	2.56	2.46	2.51	2.55	2.65
Hawaii	1.08	1.08	1.25	1.27	1.30	1.40
Idaho	1.06	0.84	1.03	1.10	1.21	1.28
Illinois	1.22	1.18	1.55	1.67	1.78	2.00
Indiana	0.83	0.87	1.09	1.17	1.26	1.39
Iowa	1.00	0.96	1.18	1.23	1.29	1.37
Kansas	1.05	0.87	0.99	1.05	1.14	1.26
Kentucky	2.83	2.65	3.11	3.27	3.42	3.71
Louisiana	3.90	2.87	3.15	3.29	3.49	3.84
Maine	2.31	1.89	1.93	1.97	2.03	2.17
Maryland	1.17	1.16	1.25	1.30	1.35	1.44
Massachusetts	2.30	1.91	1.98	2.12	2.23	2.40
Michigan	1.31	1.35	1.54	1.61	1.71	1.93
Minnesota	1.00	0.78	0.92	0.99	1.05	1.17
Mississippi	5.21	4.28	4.42	4.56	4.68	4.98
Missouri	2.10	1.58	1.66	1.75	1.83	1.96
Montana	1.12	0.92	1.25	1.33	1.38	1.44
Nebraska	1.06	0.88	0.99	1.05	1.09	1.19
Nevada	1.00	0.85	0.95	0.98	1.04	1.14
New Hampshire	0.67	0.62	0.62	0.68	0.71	0.77
New Jersey	1.11	1.23	1.36	1.44	1.52	1.66
New Mexico	2.29	1.83	2.08	2.19	2.25	2.39
New York	2.24	2.00	2.31	2.46	2.60	2.85
North Carolina	2.71	2.21	2.24	2.33	2.36	2.47
North Dakota	1.25	0.96	1.17	1.25	1.30	1.34
Ohio	1.22	1.19	1.44	1.55	1.63	1.84
Oklahoma	3.03	1.81	1.92	1.97	2.02	2.13
Oregon	1.12	0.95	1.11	1.18	1.24	1.35
Pennsylvania	1.24	1.39	1.60	1.69	1.77	1.90
Rhode Island	1.72	1.62	1.74	1.83	1.91	2.05
South Carolina	2.84	2.60	2.59	2.61	2.67	2.80
South Dakota	1.32	1.19	1.45	1.53	1.62	1.72
Tennessee	3.24	2.71	2.87	2.98	3.06	3.22
Texas	2.23	1.57	1.73	1.81	1.87	2.00
Utah	0.76	0.53	0.73	0.79	0.84	0.94
Vermont	1.93	1.76	1.79	1.89	1.99	2.08
Virginia	1.53	1.49	1.54	1.61	1.67	1.76
Washington	1.46	1.09	1.27	1.34	1.39	1.50
West Virginia	2.37	2.24	2.63	2.78	2.91	3.17
Wisconsin	1.44	1.50	1.75	1.83	1.88	2.04
Wyoming	0.67	0.45	0.76	0.85	0.92	1.04
Total ¹	2.00	1.74	1.94	2.03	2.11	2.26

¹ The total number of SSI recipients used to calculate the total reciprocity rate includes a certain number of recipients whose State is unknown. For 1975, 1985, 1990, 1991, 1992, and 1993, the numbers of unknown (in thousands) respectively were 256, 14, 0, 96, 71, and 91.

Source: Social Security Administration and Committee staff. Percentages are calculated as the average number of monthly SSI recipients over the total population of each State in July of the selected year.

TABLE 6-20.—SSI RECIPIENCY RATES BY STATE, AND PROGRAM TYPE, FOR 1979 AND 1993

[In percent]

State	Total reciprocity rate			Adult reciprocity rate ¹			Aged reciprocity rate		
	1979	1993	Percent change 1979-93	1979	1993	Percent change 1979-93	1979	1993	Percent change 1979-93
Alabama	3.55	3.64	2.5	1.83	2.69	47.0	21.01	11.35	-46.0
Alaska	0.77	0.96	24.7	0.54	0.89	64.8	14.04	6.41	-54.3
Arizona	1.11	1.54	38.7	0.89	1.44	61.8	4.98	3.52	-29.3
Arkansas	3.50	3.66	4.6	1.87	2.67	42.8	17.05	9.74	-42.9
California	3.02	3.14	4.0	2.05	2.44	19.0	16.43	13.76	-16.3
Colorado	1.10	1.38	25.5	0.77	1.26	63.6	6.68	3.76	-43.7
Connecticut	0.75	1.19	58.7	0.63	1.15	82.5	2.70	2.49	-7.7
Delaware	1.19	1.34	12.6	0.94	1.17	24.5	5.43	3.19	-41.3
District of Columbia	2.28	3.21	40.8	1.92	2.72	41.7	8.56	8.08	-5.6
Florida	1.78	2.06	15.7	1.14	1.51	32.5	6.21	4.90	-21.1
Georgia	2.87	2.65	-7.7	1.89	2.05	8.5	17.73	10.44	-41.1
Hawaii	1.05	1.40	33.3	0.69	1.03	49.3	7.57	5.95	-21.4
Idaho	0.79	1.28	62.0	0.64	1.25	95.3	3.78	2.38	-37.0
Illinois	1.08	2.00	85.2	0.95	1.98	108.4	4.25	3.77	-11.3
Indiana	0.75	1.39	85.3	0.61	1.37	124.6	3.32	2.18	-34.3
Iowa	0.89	1.37	53.9	0.62	1.37	121.0	3.50	2.25	-35.7
Kansas	0.89	1.26	41.6	0.63	1.23	95.2	3.47	2.15	-38.0
Kentucky	2.54	3.71	46.1	1.79	3.49	95.0	12.54	8.92	-28.9
Louisiana	3.35	3.84	14.6	2.03	2.99	47.3	20.14	11.37	-43.5

Maine	1.95	2.17	11.3	1.39	2.02	45.3	8.58	5.52	-35.7
Maryland	1.15	1.44	25.2	0.94	1.22	29.8	5.40	4.45	-17.6
Massachusetts	2.24	2.40	7.1	1.28	2.14	67.2	10.80	6.08	-43.7
Michigan	1.26	1.93	53.2	1.07	1.95	82.2	5.85	3.59	-38.6
Minnesota	0.81	1.17	44.4	0.55	1.14	107.3	3.71	2.55	-31.3
Mississippi	4.49	4.98	10.9	2.42	3.65	50.8	26.01	16.47	-36.7
Missouri	1.76	1.96	11.4	1.10	1.80	63.6	7.89	4.07	-48.4
Montana	0.89	1.44	61.8	0.72	1.54	113.9	3.79	2.50	-34.0
Nebraska	0.88	1.19	35.2	0.64	1.16	81.3	3.38	2.18	-35.5
Nevada	0.84	1.14	35.7	0.53	0.97	83.0	5.87	3.50	-40.4
New Hampshire	0.58	0.77	32.8	0.44	0.77	75.0	2.53	1.55	-38.7
New Jersey	1.14	1.66	45.6	0.86	1.34	55.8	4.69	4.46	-4.9
New Mexico	1.97	2.39	21.3	1.37	1.97	43.8	12.36	8.27	-33.1
New York	2.12	2.85	34.4	1.59	2.27	42.8	8.26	8.36	1.21
North Carolina	2.40	2.47	2.9	1.58	1.84	16.5	13.60	8.13	-40.2
North Dakota	0.99	1.34	35.4	0.57	1.24	117.5	5.05	3.18	-37.0
Ohio	1.11	1.84	65.8	0.99	1.90	91.9	4.17	2.76	-33.8
Oklahoma	2.32	2.13	-8.2	1.33	1.73	30.1	11.62	5.99	-48.5
Oregon	0.86	1.35	57.0	0.70	1.38	97.1	3.28	2.52	-23.2
Pennsylvania	1.40	1.90	35.7	1.12	1.79	59.8	4.96	3.51	-29.2
Rhode Island	1.59	2.05	28.9	1.08	1.83	69.4	6.43	4.80	-25.3
South Carolina	2.69	2.80	4.1	1.78	2.13	19.7	16.96	9.59	-43.5
South Dakota	1.14	1.72	50.9	0.72	1.57	118.1	4.99	3.66	-26.7
Tennessee	2.86	3.22	12.6	1.87	2.76	47.6	14.77	9.02	-38.9
Texas	1.89	2.00	5.8	0.95	1.39	46.3	12.69	8.83	-30.4
Utah	0.55	0.94	70.9	0.51	1.04	103.9	3.03	1.97	-35.0

NUMBER OF RECIPIENTS: 1970-93

Table 6-21 illustrates the changes in the number of individuals receiving assistance under the federally administered SSI program and prior programs. The total number of individuals receiving assistance was 3.1 million in 1970; this increased to 4.3 million in 1975 and declined to 3.9 million in 1982. Since then, the number of SSI recipients has grown each year. In 1993, there were over 5.9 million SSI recipients. The number of aged receiving SSI has declined sharply since 1975 from 2.3 million (or 2.5 million if disabled over age 65 are counted as aged) to 1.5 million individuals in 1993 (2.1 million if disabled over 65 are counted). The number of blind or disabled receiving assistance increased sharply from 1.0 million in 1970 to roughly 4.3 million in 1993 (3.8 million if persons over age 65 are excluded).

New SSI eligibility criteria for disabled children

Under SSI law, a child under age 18 who has an impairment of comparable severity with that of an adult may be considered disabled. On February 20, 1990, the Supreme Court ruled in *Sullivan v. Zebley* that the Social Security Administration was improperly determining the eligibility of disabled children for the SSI program. Prior to the *Zebley* decision, for both adults and children, an applicant's condition was compared to a listing of impairments. If it met or equalled a listing, the disability criteria for SSI was met. However, children were evaluated only against the listing, while adults whose condition did not meet or equal a listing were given an individual functional assessment (called a residual functional capacity assessment) to determine disability. In the *Zebley* case, the Supreme Court held that determinations of children's eligibility for SSI also must take into account functional limitations.

The court order defined the *Zebley* class entitled to readjudication and, possibly, retroactive benefits as all title XVI childhood disability claimants who have received a less than favorable decision of the Secretary or whose claims for SSI childhood disability were terminated on or after January 1, 1980, through February 11, 1991, based on medical grounds. January 1, 1980, was the compromise date agreed to by both parties. The plaintiffs supported offering readjudication to all children denied benefits on medical grounds since the beginning of the SSI program in 1974, while the Social Security Administration advocated a retroactive period starting on the date *Zebley* was filed, July 12, 1983. The closing date of the retroactive class, February 11, 1991, is the date on which the Social Security Administration published the revised regulation for determining disability in children.

TABLE 6-21.—NUMBER OF PERSONS RECEIVING FEDERALLY ADMINISTERED SSI PAYMENTS, 1974-99; AND ADULT ASSISTANCE UNDER PRIOR PROGRAMS, 1970-73

[In thousands]

Year ¹	Total ²	Aged ³	Blind or disabled		Federal SSI ⁶	State supplemental only
			Total ⁴	65 and older ⁵		
1970	3,098	2,082	1,016	.....	.....	.....
1971	3,172	2,024	1,148	.....	.....	.....
1972	3,182	1,934	1,248	.....	.....	.....
1973	3,173	1,820	1,353	.....	.....	.....
1974	3,996	2,286	1,710	(7)	(8)	(8)
1975	4,314	2,307	2,007	201	3,893	421
1976	4,236	2,148	2,088	249	3,799	437
1977	4,238	2,051	2,187	302	3,778	460
1978	4,217	1,968	2,249	344	3,755	462
1979	4,150	1,872	2,278	386	3,687	462
1980	4,142	1,808	2,334	419	3,682	460
1981	4,019	1,678	2,341	443	3,590	429
1982	3,858	1,549	2,309	462	3,473	384
1983	3,901	1,515	2,386	485	3,590	311
1984	4,029	1,530	2,499	507	3,699	331
1985	4,138	1,504	2,634	525	3,799	339
1986	4,269	1,473	2,796	540	3,922	348
1987	4,385	1,455	2,930	560	4,019	366
1988	4,464	1,433	3,030	573	4,089	375
1989	4,593	1,439	3,154	587	4,206	387
1990	4,817	1,454	3,363	605	4,412	405
1991	5,118	1,465	3,654	615	4,730	389
1992	5,566	1,471	4,095	628	5,202	364
1993	6,011	1,475	4,536	680	5,664	347
1994 ⁹	6,525	1,478	5,047	757	6,172	353
1995 ⁹	7,025	1,481	5,544	831	6,665	360
1996 ⁹	7,503	1,487	6,016	902	7,135	368
1997 ⁹	7,954	1,493	6,461	969	7,579	375
1998 ⁹	8,383	1,498	6,885	1,033	8,001	382
1999 ⁹	8,792	1,503	7,289	1,093	8,404	388

¹ Data are for December of each year.² All persons with Federal SSI payments and/or Federally administered State supplementation; 1974-1994. For 1970-1973, the total is the number of recipients under the Old-Age Assistance and Aid to the Blind and Aid to the Permanently and Totally Disabled Programs.³ For 1970-1973, this column is the number of recipients under the Old-Age Assistance program.⁴ For 1970-1973, this column is the number of recipients under the Aid to the Blind and Aid to the Permanently and Totally Disabled Programs.⁵ For 1974-1999, this is the number of age 65 or older individuals who first received SSI benefits because of being blind or disabled.⁶ All persons with Federal SSI payments include those receiving Federal payments only or both Federal SSI and Federally administered State supplementation.⁷ Data not available for December 1974. In January 1974, there were 87,000 blind and disabled recipients aged 65 or older.⁸ Data not available.⁹ For 1994-1999, data are projections based on the President's budget estimates of December 1993.

Source: Office of Supplemental Security Income, Social Security Administration.

TABLE 6-22.—NUMBER OF PERSONS RECEIVING SSI PAYMENTS, BY STATE, DECEMBER 1993

State	Federally administered ¹				State administered total ⁵
	Total	Aged	Blind	Disabled	
Total ¹	5,984,330	1,474,852	85,456	4,424,022	314,030
Alabama ²	155,734	42,496	1,611	111,627	3,001
Alaska ²	5,909	1,204	109	4,596	4,726
Arizona ²	63,033	12,985	817	49,231	694
Arkansas	90,582	23,335	1,186	66,061	.....
California	994,213	335,845	22,602	635,766	.....
Colorado ²	51,055	9,556	514	40,985	31,377
Connecticut ²	40,233	7,597	525	32,111	29,155
Delaware	9,696	1,684	124	7,888	.....
District of Columbia	18,836	3,453	204	15,179	.....
Florida ³	292,769	93,638	3,260	195,871	14,237
Georgia	186,808	47,024	2,648	137,136	.....
Hawaii	16,967	6,898	159	9,910	.....
Idaho ²	14,477	2,000	142	12,335	2,985
Illinois ²	244,950	35,029	2,526	207,395	60,055
Indiana ²	81,976	10,247	1,135	70,594	1,128
Iowa	39,379	6,581	1,015	31,783	.....
Kansas	32,997	4,904	395	27,698	.....
Kentucky ²	145,668	26,702	1,881	117,085	6,367
Louisiana	170,483	36,302	2,293	131,888	.....
Maine	27,817	6,366	284	21,167	.....
Maryland ³	73,529	16,462	810	56,257	1,132
Massachusetts	148,615	47,117	4,519	96,979	.....
Michigan	192,390	25,162	2,178	165,050	.....
Minnesota ²	54,881	10,255	761	43,865	21,339
Mississippi	134,318	35,951	1,563	96,804	.....
Missouri ²	105,042	19,227	1,113	84,702	11,283
Montana	12,406	1,781	129	10,496	.....
Nebraska ²	19,523	3,379	253	15,891	6,619
Nevada	16,789	5,350	547	10,892	.....
New Hampshire ²	8,980	1,389	96	7,495	5,804
New Jersey	134,285	34,800	1,176	98,309	.....
New Mexico ²	39,993	9,823	620	29,550	281
New York	536,018	139,921	3,944	392,153	.....
North Carolina ²	174,526	45,289	2,602	126,635	17,951
North Dakota ⁴	8,600	1,982	95	6,523	267
Ohio	214,038	23,022	2,543	188,473	.....
Oklahoma ²	69,954	16,968	977	52,009	65,298
Oregon ²	42,571	7,036	636	34,899	16,743
Pennsylvania	236,354	42,841	2,811	190,702	.....
Rhode Island	21,309	5,011	224	16,074	.....
South Carolina ²	103,812	26,262	1,794	75,756	4,330
South Dakota ³	12,515	2,652	148	9,715	217
Tennessee	167,590	36,889	1,995	128,706	.....
Texas ⁴	370,719	126,703	5,558	238,458	.....
Utah	18,199	2,157	307	15,735	.....

TABLE 6-22.—NUMBER OF PERSONS RECEIVING SSI PAYMENTS, BY STATE, DECEMBER 1993—Continued

State	Federally administered ¹				State administered total ⁵
	Total	Aged	Blind	Disabled	
Vermont	12,176	2,243	123	9,810	.....
Virginia ²	117,809	29,363	1,603	86,843	6,694
Washington	81,634	12,558	890	68,186	.....
West Virginia ⁴	60,202	8,369	736	51,097	.....
Wisconsin	106,198	20,110	1,201	84,887	.....
Wyoming ²	5,154	710	60	4,384	2,347
Other:					
N. Mariana Islands	532	213	14	305	.....

¹ Includes fewer than 200 cases not distributed by State.

² Data for Federal SSI payments only. State has state-administered supplementation.

³ Data for Federal SSI payments and Federally administered state supplementation only. State also has state-administered supplementation.

⁴ Data for Federal SSI payments only. State supplementary payments not made.

⁵ Represents September 1993 data.

Source: Office of Research and Statistics and Office of Supplemental Security Income, Social Security Administration.

Impact of the Sullivan v. Zebley decision

In March 1991, the district court approved a settlement agreement that established an eligible class under *Zebley* back to January 1980. Implementation of this settlement required an intensive effort to locate children who were denied benefits from January 1, 1980, to February 11, 1991. Notices were sent to approximately 452,000 individuals. Of this number, close to 321,700 have responded accounting for about 71 percent of potential class members. According to SSA, when the additional recipients who filed new claims or were processed as a result of the *Zebley* case or related childhood disability regulations were added to the rolls, the number of blind/disabled childhood recipients increased by 86,000 in fiscal year 1991 and 169,000 in fiscal year 1992 and 146,600 in fiscal year 1993.

Presumptive SSI eligibility for persons with AIDS and HIV

SSI law permits benefits to be paid to a person applying for SSI benefits on the basis of disability or blindness before a formal determination of disability or blindness has been made when available information indicates a high probability that the person is disabled or blind and the person is otherwise eligible.

Section 1631(a)(4)(B) of the Social Security Act provides that the Secretary of the Department of Health and Human Services may pay up to 6 months of SSI benefits to a person applying for SSI based on disability or blindness prior to the determination of the individual's disability or blindness if the individual is presumptively disabled or blind and otherwise eligible. A finding of presumptive disability or blindness may be made at the Social Security field offices only for specified impairment categories (because the field office employees generally are not trained disability adju-

dicators); however, at the State agencies (where there are disability adjudicators) they may be made for any impairment category.

On February 11, 1985, acquired immunodeficiency syndrome (AIDS), as defined by the Centers for Disease Control, was added (pursuant to interim Federal regulations) to the impairment categories, thus allowing field offices to find presumptive disability for persons claiming they had AIDS. These regulations were scheduled to expire February 11, 1988, but were extended until December 31, 1989; and in 1989 they were extended until December 31, 1991. In December 1991, a new more liberal regulation was implemented. Under the new procedures, the Social Security field offices may make a finding of presumptive disability for any individual with the human immunodeficiency virus (HIV) whose disease manifestations are of listing-level severity, not only to those who have been diagnosed with AIDS.

ELIGIBILITY OF DRUG ADDICTS AND ALCOHOLICS FOR SSI

The SSI program has the authority to award SSI disability payments on the grounds of drug addiction or alcoholism. Under the SSI program an individual is considered to be a medically determined drug addict or alcoholic only if (1) he or she is disabled (as defined by SSI law), and (2) drug addiction or alcoholism is a contributing factor to such disability. The presence of a condition diagnosed or defined as addiction to alcohol or drugs does not by itself qualify an individual for SSI benefits.

Section 1631(a)(2)(A) of the Social Security Act requires SSI recipients disabled because of drug addiction or alcoholism to have a representative payee; section 1611(e)(3)(A) of the Social Security Act requires these recipients to participate in an approved treatment program when available and appropriate; and section 1611(e)(3)(B) of the Social Security Act requires recipients to allow their participation in the treatment program to be monitored by agencies under contract to SSA.

SSI provisions relating to drug addicts and alcoholics were contained in the original SSI law (P.L. 92-603). Initially the Senate sought to exclude these individuals from SSI by putting them in a separate program. Members of Congress thought that these drug addicts and alcoholics would need more than the cash payments that SSA could provide, that they would need treatment, case management, and close monitoring so that they would not use SSI benefits to "feed their addiction." The requirement for representative payees grew out of this latter concern.

According to data from a 1991 Department of Health and Human Services' inspector general report, about 20,000 persons diagnosed as disabled drug addicts and alcoholics are receiving SSI benefits. About 40 percent of these recipients were determined to be disabled only after appealing their case to an Administrative Law Judge. More than half of this caseload live in either California or Illinois, three-fourths of the caseload is male, 41 percent are white and 37 percent are black, and most of the recipients are addicted to alcohol rather than drugs. Although 99 percent of the recipients have the required representative payee (usually a family member),

SSA provides very little monitoring and does not know whether the majority (66 percent) of the recipients are in treatment.¹

In December 1993, there were about 79,000 disabled drug addicts and alcoholics on the SSI rolls.

In 1991, SSA entered into a collaboration with the Department of Health and Human Services' Public Health Services' Substance Abuse and Mental Health Services Administration to improve referral and monitoring of treatment for SSI recipients who are drug addicts and alcoholics. As a result, SSA has established referral and monitoring services contracts with agencies in 32 States and the District of Columbia to perform numerous specified tasks to ensure both better service to SSI recipients and greater management oversight. SSA plans to have similar contracts in place in the remaining States by the end of fiscal year 1994. SSA increased funding for referral and monitoring activities from \$4 million in fiscal year 1993 to \$20 million in fiscal year 1994 and \$36 million in fiscal year 1995—an 80 percent increase—which will allow them to serve about 69,000 SSI drug addict and alcoholic recipients in fiscal year 1995.

SPECIAL SSI BENEFITS, MEDICAID SERVICES, AND RELATED PROVISIONS FOR THE WORKING DISABLED

Earned income disregards.—Since SSI began in 1974, the law has required that a portion of the earned income of SSI recipients be disregarded in determining the eligibility for and the amount of SSI benefits payable. In determining SSI eligibility and/or benefit amount, the first \$65 of monthly earned income (or, up to the first \$85 if the recipient has no unearned income) plus one-half of the remaining earnings are disregarded. In addition, any work-related expenses are disregarded in the case of blind persons and impairment-related work expenses are disregarded in the case of disabled persons. Also, income and/or resources set aside under a PASS are excluded. Earned income disregards were included in the pre-SSI federally assisted State programs for the aged, blind, and disabled.

Eliminating work disincentives.—Prior to the enactment of the section 1619 program in 1980, on a temporary 3-year basis (and continued for an additional two years as a demonstration project), a disabled SSI recipient who worked faced a substantial risk of losing SSI benefits and frequently, Medicaid. Work was treated the same way it was under the Social Security disability insurance (SSDI) program: after a trial work period, work at the substantial gainful activity (SGA) level (\$500 or more of earnings per month; \$300 per month before January 1990) led to the loss of disability status even if the individual's total income and resources were within SSI program limits. Loss of SSI disability status caused loss of Medicaid eligibility as well. (Many States provide automatic Medicaid coverage to all recipients of Federal SSI payments. Nearly all States follow the SSI definition of disability to establish Medicaid eligibility.) Thus, disabled individuals who could work or, at least, could have tried to work had a disincentive to work because

¹U.S. Department of Health and Human Services, Office of Inspector General. *Social Security Policies Concerning Drug Addicts and Alcoholics*. July 1991.

of their fear of losing their SSI benefits or often more importantly their eligibility for health services under Medicaid.

Summary of section 1619 provisions intended to remove work disincentives for the disabled

Section 1619(a) of SSI law, enacted as a permanent provision of law in 1986, provides for the continuation of cash benefits for those SSI recipients who are receiving benefits on the basis of disability even if their earnings are at or above the SGA level and as long as there is not a medical improvement in the disabling condition. The amount of their cash benefits is gradually reduced as their earnings increase under the income disregard formula until their countable earnings reach the SSI benefit standard or what is known as the "breakeven point." In a State with no supplementation, as shown in table 6-2, this earned income eligibility limit is \$977 per month in 1994 for a person who has no unearned income. People who receive the special SSI benefits continue to be eligible for Medicaid on the same basis as regular SSI recipients. States have the option of supplementing the Federal benefits standard for those entitled to benefits under this provision. The "breakeven point" increases \$2 for every \$1 of State supplementation above the Federal SSI benefit standard.

Under section 1619(b), blind and disabled individuals can continue to be eligible for Medicaid even if their earnings take them past the SSI income disregard "breakeven point." In some 209(b) States, workers may lose Medicaid eligibility before attaining 1619(b) status, if they did not have Medicaid coverage the month before section 1619 status began, thus making this provision inoperable for those workers. This special eligibility status, under which the individual is considered a blind or disabled individual receiving SSI benefits for purposes of Medicaid eligibility, applies as long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the termination of eligibility for Medicaid services; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the benefits (SSI, State supplementary payments, Medicaid and publicly funded attendant care) that would have been available if he or she did not have those earnings.

In making an initial determination under the fourth criterion, SSA decided to compare the individual's gross earnings to a "threshold" amount. The threshold amount is the amount of gross earnings, after the monthly \$20 general income, \$65 earned income and one-half of the remainder exclusions are applied, that it would take to reduce to zero the Federal SSI benefit and State supplementary payment for an individual with no other income or exclusions living in his or her own household plus the average Medicaid expenditures for disabled SSI cash recipients for the State of residence. If the individual's earnings exceed the threshold, an individualized threshold is calculated which considers the person's actual Medicaid use, the State supplement rate for the person's actual living arrangement, and the value of publicly funded attendant care available to the person in the absence of his or her earnings. In determining a person's income to compare to the individualized

threshold, any applicable exclusions are deducted from his or her earnings, including work expenses if the person is blind, impairment-related work expenses, and income set aside under a plan for achieving self-support.

In other words, Medicaid eligibility continues until the individual's earnings reach a higher plateau which takes into account the person's ability to afford medical care as well as his or her normal living expenses, or he or she medically recovers.

Under the provisions of Public Law 99-643, which was effective July 1, 1987, a disabled individual also has the ongoing protection of being able to be reinstated to eligibility for cash assistance benefits under regular SSI or 1619(a), or Medicaid only eligibility under 1619(b) if his or her work attempt fails or the physical or mental disability makes the ability to work very erratic. This protection is not indefinite, but SSA, under the provisions of Public Law 99-643, will not terminate the disability status of an individual for 12 months after his or her most recent eligibility for regular SSI or eligibility under section 1619(a) or 1619(b). However, if the individual recovers medically a new application and new disability determination would be required to establish a new period of eligibility.

SSI OUTREACH ACTIVITIES

The 1983 Social Security Amendments (P.L. 98-21) mandated the Social Security Administration (SSA) to conduct two separate outreach activities aimed at the aged population. The first was a one-time mailing of alerts to those aged individuals and couples whose Social Security benefits were less than the Supplemental Security Income (SSI) eligibility levels. Between February and July 1984, over 7.6 million notices were mailed as part of this one-time alert. SSA used a mail survey questionnaire to evaluate the effects of this alert process. As a result of the one-time outreach effort, there were approximately 160,000 field office contacts. These contacts resulted in 79,000 applications for SSI payments and 58,000 awards, with an average monthly SSI payment of \$60 to supplement these recipients' Social Security benefits. Most of the people who did not contact SSA after receiving the alert reported that they felt that they were ineligible because of too many resources or too much income.

The second outreach activity is an ongoing effort to notify two groups of Social Security beneficiaries: those about to reach age 65; and disabled individuals who have been receiving Social Security benefits for 21 consecutive months and will soon be eligible for Medicare. Beginning in July 1983, and continuing each month, approximately 110,000 aged and disabled Social Security beneficiaries receive an SSI alert which accompanies the Medicare enrollment notice. Eighty percent of the alerts go to retired beneficiaries, with the remainder sent to disability beneficiaries. The trend in SSI monthly aged awards showed a marked change when this mailing began. SSA estimates that about 2,000 additional aged awards per month have resulted from the ongoing alerts since July 1983.

As a result of these two outreach efforts, the decline in the aged SSI population was temporarily reversed, resulting in a high of 2,083,633 aged recipients in September 1984. Since that date, the

aged SSI population has begun to decrease, although at a slower rate than that experienced before the outreach.

The Omnibus Budget Reconciliation Act of 1989 established a permanent outreach program for disabled and blind children. In addition, beginning in 1989, SSA made SSI outreach an ongoing agency priority. The goal of SSA's SSI outreach strategy is to reduce the barriers that prevent or discourage potentially SSI-eligible individuals from participating in the program. Common barriers include lack of information or understanding about the program, perceived stigma from participating in the program, the complexity of the application process, and homelessness.

SSA seeks to overcome these barriers by providing better information about the program, alleviating any stigma surrounding the program, and making the program more accessible to potentially eligible persons. SSA tries to overcome these barriers both directly and through cooperative efforts with other government and private sector organizations that have contacts with local SSA field officers.

In fiscal year 1990, Congress mandated SSA to expand the scope of its SSI outreach activities and provided funding for SSA to conduct an SSI Outreach Demonstration project. To this end, Congress appropriated funding for cooperative agreements as follows: fiscal year 1990—\$3 million; fiscal year 1991—\$6 million; fiscal year 1992—\$6 million; and fiscal year 1993—\$6 million. To date, SSA has funded 82 diverse cooperative agreements targeting a variety of populations such as African-Americans, Native Americans, the homeless, the mentally ill, and people infected with HIV. SSA is in the process of awarding additional cooperative agreements which will allow it to continue testing innovative outreach methods and fill research gaps in target populations from the earlier awards.

Congress also mandated that SSA spend no less than five percent of the funding on an independent evaluation of the demonstration program. In fiscal year 1991, SSA awarded a contract for such evaluation and a cross-project comparison to develop models for effective outreach. Completed projects are in various phases of evaluation. Exemplary models will be publicized and replicated.

At the regional, State and local levels, SSA field components have implemented many creative outreach activities. SSA has established a vehicle called the Resource Information Center for collecting, sharing, and providing updates to the entire SSA field structure about these outreach efforts being conducted in regional and field offices.

At the national level, SSA has established a network of liaisons with a number of other Federal agencies that serve low-income people to improve access to the SSI program and other benefits and services. These agencies include the Department of Veterans' Affairs, Department of Agriculture, and five other Federal agencies operating under the auspices of the Federal Interagency Coordinating Council which target young children with disabilities.

SSI AND THE HOMELESS

SSA has implemented specific legislation and developed outreach programs and administrative initiatives to better meet the needs of the homeless, who may be eligible for SSI. This was prompted by evidence that approximately 30 to 40 percent of the residents of

emergency homeless shelters are chronically mentally ill, and are former residents of mental institutions.

These initiatives are designed to address the special problems related to the homeless: they are often difficult to locate and contact; they have limited ability to find information needed to apply for benefits; and they are often reluctant to follow through with the claims process or are incapable of doing so. While many of the chronically mentally ill live with family or have other ongoing contact with those who can assist them with daily living activities, the homeless, mentally ill are more likely to have very limited contact with family or others who could assist them in obtaining housing or applying for benefits.

Legislative changes enacted to address the issue of homelessness include not counting in-kind support or maintenance provided by a private nonprofit organization as income under the SSI program if determined by the State to be based on need, and allowing temporary residents of public emergency shelters to receive SSI benefits for up to 6 months in any 9-month period. SSA also has statutory authority to provide emergency advance payments in amounts up to the full SSI monthly benefit standard to individuals applying for SSI who are presumptively eligible and who have a financial emergency and payments for up to 6 months to presumptively blind and presumptively disabled individuals.

SSA has also provided assistance to the homeless by instituting several administrative initiatives. For example, in many areas of the country local field offices regularly visit homeless shelters, clinics, and hospitals to take and expedite SSI applications. SSA has also instituted special procedures on disability applications filed by homeless claimants. For example, for most applications SSA defers the nonmedical development of a claim until the States' Disability Determination Services make a favorable medical determination. However, to facilitate prompt payment to homeless claimants, SSA initiates full claims development at the time of application.

SSA has identified homelessness as one barrier to filing for SSI benefits and, in response, has initiated a wide range of outreach activities aimed at this population. For example, local field offices have established ongoing programs where local social service agencies, soup kitchens, shelters, and churches screen homeless people for possible SSI eligibility, refer them to SSA, and help them through the application process. Many of SSA's SSI outreach demonstration programs deal specifically with the homeless or concentrate on the homeless in addition to other target populations, especially individuals who suffer from mental illness or AIDS.

In August 1991, SSA began a joint project with the Department of Veterans Affairs (VA), which has two successful programs dealing with homeless, mentally ill veterans. One pilot project involves stationing SSA and State Disability Determination Services staff in VA sites to work as a team with VA clinicians to take and process applications. Another pilot involves the creation of a new position which combines SSA and State Disability Determination Services functions into one "specialist" position. The specialists also work as a team with VA clinicians. This project has shown promising results in finding and delivering benefits to eligible homeless veterans.

"Immediate payments."—Beginning in October 1985, local social security offices were given the authority to make "immediate payments" for certain Social Security and SSI cases when it is found that benefits are due but unpaid and even an expedited Treasury payment would result in deprivation of food and/or shelter or endangerment of health. "Immediate" usually means while the beneficiary waits or the next day at the latest. The payments are made using bankdrafts prepared by the SSA field office. Payments are limited to a maximum per beneficiary of \$400 or the amount due, whichever is less, in a 30-day period. The person's eligibility for benefits must be verified by the local office. During fiscal year 1993, 38,294 immediate payments were issued under this procedure. The total amount of these payments equaled \$12,666,732 for an average of \$330 per payment.

"Prerelease Procedure."—The prerelease procedure helps institutionalized individuals return to community living. Some individuals are medically ready to be released from an institution but are financially unable to support themselves. The prerelease procedure allows such individuals to apply for SSI payments and food stamps several months in advance of their anticipated release based on their probable future living arrangements so benefits can commence quickly after release. A formal prerelease agreement can be developed between an institution and the local Social Security office. However, an individual can file an application for SSI under prerelease without the existence of such an agreement.

SSI MODERNIZATION PROJECT

In 1990, the Social Security Commissioner established the SSI Modernization Project to determine the effectiveness of the SSI program. The Project's 21 outside experts published their final report in September 1992, drawing on extensive public testimony and comment. The report included more than 50 options for program improvement, many of which would require legislation and all of which would involve substantial cost. Provisions dealing with some of the issues addressed by the experts were introduced in both the 102d and 103d Congress, but none has passed. In October 1993, the House Committee on Ways and Means Subcommittee on Human Resources held an oversight hearing on SSI and heard testimony on the Modernization Project Report. In light of the need to achieve a balance in relation to efforts aimed at reducing a budget deficit and reforming health care and welfare, many legislators viewed SSI modernization legislation as too costly and expansive. The subcommittee held a subsequent hearing on the Modernization Project in March 1994.

SSI PROGRAM COSTS

Table 6-23 shows the total expenditures for the SSI program in each State, including not only the federally administered Federal and State supplementation payments but also the State administered State supplementation payments. Table 6-24 shows the total (Federal- and State-administered) State supplementation payments for SSI for fiscal years 1985 through 1993.

TABLE 6-23.—SUPPLEMENTAL SECURITY INCOME: TOTAL PAYMENTS, FEDERAL SSI PAYMENTS, AND FEDERALLY ADMINISTERED AND STATE ADMINISTERED STATE SUPPLEMENTARY PAYMENTS, FISCAL YEAR 1993

[In thousands of dollars]

State	Total	Federal SSI ¹	State supplementation	
			Federally administered ²	State administered
Total	\$24,173,827	\$20,311,676	\$3,298,496	\$563,655
Alabama	530,650	528,567	.....	2,083
Alaska	33,259	20,287	.....	⁴ 12,972
Arizona	230,533	227,404	.....	⁴ 3,129
Arkansas	299,216	299,216	(³)	.....
California	5,075,783	2,863,453	2,212,330	.....
Colorado	235,044	179,987	.....	⁴ 55,057
Connecticut	241,274	144,438	.....	96,836
Delaware	32,578	31,831	747	.....
District of Columbia	71,473	66,574	4,899	.....
Florida	1,039,971	1,021,363	(³)	18,608
Georgia	608,535	608,516	19	.....
Hawaii	68,756	57,690	11,066	.....
Idaho	55,464	51,252	.....	⁴ 4,212
Illinois	1,073,690	1,007,854	.....	⁴ 65,836
Indiana	307,664	303,847	.....	3,817
Iowa	130,027	127,168	2,859	.....
Kansas	114,553	114,553	(³)	.....
Kentucky	551,082	535,769	.....	15,313
Louisiana	692,553	692,549	4	.....
Maine	77,619	70,386	7,233	.....
Maryland	281,598	275,329	32	6,237
Massachusetts ...	583,542	435,676	147,866	.....
Michigan	762,089	699,406	62,683	.....
Minnesota	238,243	184,383	.....	⁴ 53,860
Mississippi	474,366	474,355	11	.....
Missouri	391,369	365,503	.....	⁴ 25,866
Montana	41,784	40,882	902	.....
Nebraska	72,526	65,821	.....	6,705
Nevada	57,682	54,096	3,586	.....
New Hampshire..	38,217	29,705	.....	8,512
New Jersey	521,269	449,304	71,965	.....
New Mexico	137,027	136,698	.....	329
New York	2,369,189	1,893,160	476,029	.....
North Carolina ...	646,659	551,214	.....	95,445
North Dakota	27,072	25,852	.....	1,220

TABLE 6-23.—SUPPLEMENTAL SECURITY INCOME: TOTAL PAYMENTS, FEDERAL SSI PAYMENTS, AND FEDERALLY ADMINISTERED AND STATE ADMINISTERED STATE SUPPLEMENTARY PAYMENTS, FISCAL YEAR 1993—Continued

[In thousands of dollars]

State	Total	Federal SSI ¹	State supplementation	
			Federally adminis- tered ²	State adminis- tered
Ohio	840,617	840,589	28	.....
Oklahoma	265,811	229,254	.....	36,557
Oregon	171,232	151,063	.....	⁴ 20,169
Pennsylvania	979,698	869,751	109,947	.....
Rhode Island	77,093	60,996	16,097	.....
South Carolina ...	351,169	338,792	.....	12,377
South Dakota	42,334	41,653	10	671
Tennessee	560,825	560,825	(³)	.....
Texas	1,220,944	1,220,944	.....	.....
Utah	67,627	66,749	878	.....
Vermont	44,866	34,939	9,927	.....
Virginia	402,297	384,980	.....	17,317
Washington	322,619	295,811	26,808	.....
West Virginia	232,666	232,666	.....	.....
Wisconsin	461,094	328,333	132,761	.....
Wyoming	17,137	16,610	.....	527
N. Mariana Islands	2,178	2,178	.....	.....

¹ Includes \$1.5 million not distributed by State.² Total reduced by 197,000 due to adjustments not yet identified and credited by State.³ Amount not shown; negative adjustment exceeds amount paid.⁴ Estimated data.

Source: Office of Research and Statistics, Social Security Administration.

TABLE 6-24.—STATE SSI SUPPLEMENTATION PAYMENTS FOR EACH FISCAL YEAR 1985-93
[In thousands of dollars]

State	1985	1986	1987	1988	1989	1990	1991	1992	1993
Total	\$2,234,846	\$2,496,275	\$2,835,516	\$3,006,796	\$3,308,277	\$3,589,348	\$3,750,812	\$3,987,110	\$3,862,151
Alabama	15,003	13,659	11,606	10,436	7,964	6,594	6,394	3,845	2,083
Alaska	12,970	12,970	12,970	12,970	12,970	12,972	12,972	12,972	12,972
Arizona	2,194	2,668	3,045	3,309	2,691	2,560	3,129	3,129	3,129
Arkansas	30	28	32	20	14	15	12	8	0
California	1,288,260	1,466,079	1,729,305	1,862,170	2,038,339	2,274,296	2,303,637	2,433,459	2,212,330
Colorado	47,474	38,320	35,416	24,132	41,035	42,649	50,002	53,309	55,057
Connecticut	31,200	36,578	46,577	54,584	74,257	67,670	98,838	94,725	96,836
Delaware	457	671	703	730	725	708	721	750	747
Dist. of Columbia	4,106	4,202	4,265	4,538	4,498	4,365	4,278	4,694	4,899
Florida	8,174	9,718	11,314	11,309	12,609	14,656	18,055	18,899	18,608
Georgia	13	8	19	18	10	16	9	12	19
Hawaii	3,598	3,740	3,893	4,263	6,799	10,885	10,314	10,698	11,066
Idaho	4,023	4,136	4,205	4,205	4,205	4,212	4,212	4,212	4,212
Illinois	44,491	51,197	56,856	59,573	55,716	57,137	65,756	64,241	65,836
Indiana	1,191	1,744	2,666	3,619	3,099	3,285	3,405	3,563	3,817
Iowa	1,620	1,908	2,098	2,204	2,275	2,408	2,508	2,672	2,859
Kansas	32	27	34	25	21	21	17	12	0
Kentucky	9,947	9,795	10,109	10,467	10,473	11,611	14,801	15,492	15,313
Louisiana	51	42	47	33	23	25	19	12	4
Maine	5,372	5,413	7,454	7,540	7,452	7,494	7,371	7,325	7,233
Maryland	4,238	5,252	5,505	6,159	6,159	6,155	6,520	6,542	6,269
Massachusetts	109,954	109,452	112,561	120,010	114,691	117,113	124,761	137,516	147,866
Michigan	62,824	66,338	68,779	69,833	72,369	74,682	72,561	61,636	62,683
Minnesota	17,024	19,818	22,850	24,667	40,641	43,924	48,933	55,224	53,860
Mississippi	33	29	35	27	26	22	19	12	11
Missouri	6,027	5,132	4,410	4,009	3,102	2,808	8,476	26,158	25,866
Montana	805	834	844	839	842	864	910	909	902
Nebraska	5,325	5,348	5,457	5,454	6,550	5,793	5,334	6,175	6,705
Nevada	2,421	2,531	2,594	2,704	2,771	2,928	3,029	3,184	3,386

New Hampshire	7,740	7,326	6,501	5,865	9,662	6,843	7,675	7,948	8,512
New Jersey	46,675	48,124	49,996	50,446	59,291	53,697	57,328	64,765	71,965
New Mexico	226	216	280	248	270	263	307	333	329
New York	225,075	277,035	305,678	317,504	366,972	388,150	410,081	440,374	476,029
North Carolina	36,449	41,091	47,963	52,745	58,989	63,135	75,066	91,925	95,445
North Dakota	1,183	1,518	1,406	1,480	1,549	1,390	1,291	1,408	1,220
Ohio	1	35	37	31	30	34	31	31	28
Oklahoma	30,187	31,380	32,894	34,045	33,414	34,168	35,055	36,012	36,557
Oregon	9,781	9,767	10,342	11,843	15,419	17,946	20,169	20,169	20,169
Pennsylvania	65,203	69,186	75,502	74,670	76,565	79,571	84,668	94,971	109,947
Rhode Island	8,842	9,402	9,848	10,263	10,816	11,729	12,973	14,967	16,097
South Carolina	3,932	4,812	4,927	5,004	9,785	8,897	11,994	11,685	12,377
South Dakota	499	591	636	587	590	567	620	652	681
Tennessee	6	0	6	1	4	4	1	1	0
Texas ¹	0	0	0	0	0	0	0	0	0
Utah	820	872	855	1,086	981	808	898	959	878
Vermont	6,709	7,236	7,684	7,841	8,346	8,685	9,374	10,299	9,927
Virginia	11,267	12,164	12,846	14,432	15,949	15,296	16,863	16,782	17,317
Washington	20,022	17,443	19,424	18,058	18,994	19,915	21,558	24,043	26,808
West Virginia ¹	0	0	0	0	0	0	0	0	0
Wisconsin	71,733	80,288	86,363	90,642	95,205	100,276	107,543	118,063	132,761
Wyoming	199	216	218	226	296	279	326	440	527

¹ Texas and West Virginia do not pay State supplementation.

Source: Social Security Administration.

Table 6-25 illustrates the total amount of Federal and State benefit payments from calendar years 1970 to 1987 and fiscal years 1988 to 1999. From 1970 to 1973, these were the benefits under the old-age assistance, aid to the blind, and aid to the permanently and totally disabled programs. In fiscal year 1993, Federal benefit payments totaled \$20,312 billion and State payments totaled \$3,862 billion.

TABLE 6-25.—FEDERAL AND STATE BENEFIT PAYMENTS UNDER SSI AND PRIOR ADULT ASSISTANCE PROGRAMS, CALENDAR YEARS 1970-87 AND FISCAL YEARS 1988-99¹

[Outlays in millions of dollars]

Year ²	Total	Total constant 1993 dollars	Federal payments	Total State payments	State payments		SSI administrative costs (fiscal year)
					Federally administered	State administered	
1970	2,939	10,870	1,801	1,138	.....	.....	.....
1971	3,206	11,360	(³)	(³)	.....	.....	.....
1972	3,392	11,645	1,993	1,398	.....	.....	.....
1973	3,418	11,047	1,987	1,432	.....	.....	.....
1974	5,246	15,270	3,833	1,413	1,264	149	⁴ 285
1975	5,878	15,678	4,314	1,565	1,403	162	399
1976	6,066	15,298	4,512	1,554	1,388	166	500
1977	6,306	14,933	4,703	1,603	1,431	172	NA
1978	6,552	14,420	4,881	1,671	1,491	180	539
1979	7,075	13,984	5,279	1,796	1,590	207	610
1980	7,941	13,829	5,866	2,074	1,848	226	668
1981	8,593	13,565	6,518	2,076	1,839	237	718
1982	8,981	13,355	6,907	2,074	1,798	276	779
1983	9,404	13,549	7,423	1,981	1,711	270	830
1984	10,372	14,325	8,281	2,091	1,792	299	864
1985	11,060	14,750	8,777	2,283	1,973	311	953
1986	12,081	15,818	9,498	2,583	2,243	340	1,022
1987	12,951	16,360	10,029	2,922	2,563	359	976
1988	14,375	17,631	11,368	3,007	2,645	362	975
1989	14,707	17,214	11,399	3,308	2,881	427	1,051
1990	16,095	17,946	12,507	3,589	3,159	431	1,075
1991	17,979	19,083	14,228	3,751	3,235	516	1,257
1992	21,258	21,899	17,270	3,987	3,431	556	1,538
1993	24,173	24,173	20,312	3,862	3,298	564	1,467
1994 ⁴	28,628	27,871	24,475	4,153	3,545	608	1,690
1995 ⁴	29,955	28,355	26,085	3,870	3,215	655	1,956
1996 ⁴	30,591	28,104	26,985	3,606	2,900	706	1,620
1997 ⁴	36,310	32,363	32,465	3,845	3,085	760	1,798
1998 ⁴	39,754	34,366	35,915	3,839	3,020	819	1,808
1999 ⁴	43,623	35,425	39,430	3,833	2,950	883	1,832

¹ Payments and adjustments during the respective year but not necessarily accrued for that year.

² 1970-1973 refers to Old-Age Assistance, Aid to the Blind and Aid to the Permanently and Totally Disabled; 1974-99 refers to Supplemental Security Income.

³ Data not available.

⁴ Estimated.

Source: Office of SSI, and Office of Budget, Social Security Administration.

MEDICAID ¹⁷

Medicaid, authorized under title XIX of the Social Security Act, is a Federal-State matching entitlement program providing medical assistance for low-income persons who are aged, blind, disabled, members of families with dependent children and certain other pregnant women and children. Within Federal guidelines, each State designs and administers its own program. Thus there is substantial variation among the States in terms of persons covered, types and scope of benefits offered, and amounts of payments for services.

Medicaid eligibility is generally linked to eligibility under programs within the jurisdiction of the Committee on Ways and Means, namely AFDC and SSI. Further, some poor aged persons are covered under both the Medicare and Medicaid programs.

ELIGIBILITY

Eligibility for Medicaid has traditionally been linked to actual or potential receipt of cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. Legislation in the last decade has gradually extended coverage to low-income pregnant women and children who have no ties to the welfare system, and has provided partial coverage for new groups of low-income Medicare beneficiaries.

Medicaid is available to two broad classes of eligible persons: the "categorically needy" and the "medically needy." The two terms once distinguished between welfare-related beneficiaries and those qualifying only under special Medicaid rules. However, nonwelfare groups have been added to the "categorically needy" list over the years. As a result, the terms are no longer especially helpful in sorting out the various populations for whom mandatory or optional Medicaid coverage has been made available, and some analysts believe they should be abandoned. However, the distinction between the categorically and medically needy is still an important one, because the scope of covered services that States must provide to the categorically needy is much broader than the minimum scope of services for the medically needy.

All States must cover certain mandatory groups of categorically needy individuals.¹⁸ Coverage of additional categorically needy groups is optional, as is coverage of the medically needy. The following discussion describes the mandatory and optional categorically eligible groups within each of the two basic populations served by Medicaid: families with children and the aged, blind, and disabled. The medically needy are discussed separately at the end of this section.

¹⁷ For further information on the Medicaid program see: U.S. Congress, House Committee on Energy and Commerce, *Medicaid Source Book: Background Data and Analysis* (A 1993 Update), Energy and Commerce Committee Print 103-A. U.S. Govt. Print. Off. January 1993.

¹⁸ Arizona does not operate a traditional Medicaid program. Since 1982 it has operated a federally assisted medical assistance program for low-income persons under a demonstration waiver.

FAMILIES AND CHILDREN

AFDC-related groups

Mandatory.—States must provide Medicaid to all persons receiving cash assistance under AFDC, as well as to additional AFDC-related groups who are not actually receiving cash payments. These groups include: persons who do not receive a payment because the amount would be less than \$10; persons whose payments are reduced to zero because of recovery of previous overpayments; certain work supplementation participants; certain children for whom adoption assistance agreements are in effect or for whom foster care payments are being made under title IV-E of the Social Security Act; and persons ineligible for AFDC because of a requirement that may not be imposed under Medicaid.

States are required to continue Medicaid for specified periods for certain families losing AFDC benefits after receiving them in at least 3 of the preceding 6 months. If the family loses AFDC benefits because of increased income from earnings or hours of employment, Medicaid coverage must be extended for 12 months. (During the second 6 months a premium may be imposed, the scope of benefits may be limited, or alternate delivery systems may be used.) If the family loses AFDC because of increased child or spousal support, coverage must be extended for 4 months. States are also required to furnish Medicaid to certain two-parent families whose principal earner is unemployed and who are not receiving cash assistance because the State is one of those permitted (under the Family Support Act of 1988) to set a time limit on AFDC coverage for such families.

Optional.—States are permitted, but not required, to provide coverage to additional AFDC-related groups. The most important of these are the "Ribicoff children," whose income and resources are within AFDC standards but who do not meet the definition of "dependent child." States may cover these children up to a maximum age of 18, 19, 20, or 21, at the State's option, and may limit coverage to reasonable subgroups, such as children in privately subsidized foster care, or those who live in certain institutional settings. States may also furnish Medicaid to persons who would receive AFDC if the State's AFDC program were as broad as permitted under Federal law.

Non-AFDC pregnant women and children

Beginning in 1986, Congress has extended Medicaid to groups of pregnant women and children who are defined in terms of family income and resources, rather than in terms of their ties to the AFDC program.

Mandatory.—States are required to cover pregnant women and children under age 6 with family incomes below 133 percent of the Federal poverty income guidelines. (The State may impose a resource standard that is no more restrictive than that for SSI, in the case of pregnant women, or AFDC, in the case of children.) Coverage for pregnant women is limited to services related to the pregnancy or complications of the pregnancy; children receive full Medicaid coverage.

Since July 1, 1991, States have been required to cover all children who are under age 19, who were born after September 30, 1983, and whose family income is below 100 percent of the Federal poverty level. (Coverage of such children through age 7 has been optional since OBRA 1987.) The 1983 start date means that coverage of 18-year-olds will take effect during fiscal year 2002.

Optional.—States are permitted, but not required, to cover pregnant women and infants under one year old with incomes below a State-established maximum that is above 133 percent of the poverty level but no more than 185 percent. As of July 1993, 34 States had made use of this option; 25 had set their income limits at the maximum of 185 percent.

AGED AND DISABLED PERSONS

SSI-related groups

Mandatory.—States are generally required to cover recipients of SSI. However, States may use more restrictive eligibility standards for Medicaid than those for SSI if they were using those standards on January 1, 1972 (before the implementation of SSI). States that have chosen to apply at least one more restrictive standard are known as “section 209(b)” States, after the section of the Social Security Amendments of 1972 (Public Law 92–603) that established the option. These States may vary in their definition of disability, or in their standards related to income or resources. There are 12 section 209(b) States:

Connecticut	Minnesota	North Dakota
Hawaii	Missouri	Ohio
Illinois	New Hampshire	Oklahoma
Indiana	North Carolina	Virginia

States using more restrictive income standards must allow applicants to deduct medical expenses from income (not including SSI or State supplemental payments, SSP) in determining eligibility. This process is known as “spenddown.” For example, if an applicant has a monthly income of \$400 (not including any SSI or SSP) and the State’s maximum allowable income is \$350, the applicant would be required to incur \$50 in medical expenses before qualifying for Medicaid. As will be discussed below, the spenddown process is also used in establishing medically needy eligibility.

States must continue Medicaid coverage for several defined groups of individuals who have lost SSI or SSP eligibility. The “qualified severely impaired” are disabled persons who have returned to work and have lost eligibility as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all non-disability criteria for SSI except income. Medicaid must be continued if such an individual needs continued medical assistance to continue employment and the individual’s earnings are insufficient to provide the equivalent of SSI, Medicaid, and attendant care benefits the individual would qualify for in the absence of earnings. States must also continue Medicaid coverage for persons who were once eligible for both SSI and Social Security payments and who lose SSI because of a cost of living adjustment (COLA) in their Social Security benefits. Similar Medicaid continuations have been provided for certain other persons who lose SSI

as a result of eligibility for or increases in Social Security or veterans' benefits. Finally, States must continue Medicaid for certain SSI-related groups who received benefits in 1973, including "essential persons" (persons who care for a disabled individual).

Optional.—States are permitted to provide Medicaid to individuals who are not receiving SSI but are receiving State-only supplementary cash payments.

Qualified Medicare beneficiaries and related groups

Mandatory.—Effective January 1, 1991, States must provide limited Medicaid coverage for "qualified Medicare beneficiaries" (QMBs). These are aged and disabled persons who are receiving Medicare, whose income is below 100 percent of the Federal poverty level, and whose resources do not exceed twice the allowable amount under SSI. States must pay Medicare part B premiums (and, if applicable, part A premiums) for QMBs, along with required Medicare coinsurance and deductible amounts.

Effective January 1, 1993, all States must pay part B premiums (but not part A premiums or part A or B coinsurance and deductibles) for beneficiaries who would be QMBs except that their incomes are between 100 percent and 110 percent of the poverty level; the upper limit rises to 120 percent on January 1, 1995.

States are also required to pay part A premiums, but no other expenses, for "qualified disabled and working individuals." These are persons who formerly received Social Security disability benefits and hence Medicare, have lost eligibility for both programs, but are permitted under Medicare law to continue to receive Medicare in return for payment of the part A premium. Medicaid must pay this premium on behalf of such individuals who have incomes below 200 percent of poverty and resources no greater than twice the SSI standard.

Optional.—States are permitted to provide full Medicaid benefits, rather than just Medicare premiums and cost-sharing, to QMBs who meet a State-established income standard that is no higher than 100 percent of the Federal poverty level.

Institutionalized persons and related groups (all optional)

States may provide Medicaid to certain otherwise ineligible groups of persons who are in nursing facilities or other institutions, or who would require institutional care if they were not receiving alternative services at home or in the community.

States may establish a special income standard for institutionalized persons, not to exceed 300 percent of the maximum SSI benefits payable to a person who is living at home and has no other resources. States may also provide Medicaid to persons who would qualify for SSI but for the fact that they are in an institution.

A State may obtain a waiver under section 2176 of OBRA 1981 to provide home and community-based services to a defined group of individuals who would otherwise require institutional care. Persons served under such a waiver may receive Medicaid coverage if they would be eligible if in an institution. Such individuals may also be covered in a State that terminates its waiver program in order to take advantage of a new, no-waiver home and community-based services option created by OBRA 1990.

A State may also provide Medicaid to several other classes of persons who need the level of care provided by an institution and would be eligible if they were in an institution. These include children who are being cared for at home, persons of any age who are ventilator-dependent, and persons receiving hospice benefits in lieu of institutional services.

THE MEDICALLY NEEDEY (ALL OPTIONAL)

Forty-one States and other jurisdictions provide Medicaid to at least some groups of "medically needy" persons. These are persons who meet the nonfinancial standards for inclusion in one of the groups covered under Medicaid, but who do not meet the applicable income or resource requirements for categorically needy eligibility. The State may establish higher income or resource standards for the medically needy. In addition, individuals may spend down to the medically needy standard by incurring medical expenses, in the same way that SSI recipients in section 209(b) States may spend down to Medicaid eligibility. For the medically needy, spenddown may involve the reduction of assets, as well as of income.

The State may set its separate medically needy income standard for a family of a given size at any level up to 133 $\frac{1}{3}$ percent of the maximum payment for a similar family under the State's AFDC program. States may limit the groups of individuals who may receive medically needy coverage. If the State provides any medically needy program, however, it must include all children under 18 who would qualify under one of the mandatory categorically needy groups, and all pregnant women who would qualify under either a mandatory or optional group, if their income or resources were lower.

As of October 1, 1993, the following States covered some groups of the medically needy:

American Samoa	Maryland	Pennsylvania
Arkansas	Massachusetts	Puerto Rico
California	Michigan	Rhode Island
Connecticut	Minnesota	Tennessee
District of Columbia	Montana	Texas
Florida	Nebraska	Utah
Georgia	New Hampshire	Vermont
Hawaii	New Jersey	Virgin Islands
Illinois	New York	Virginia
Iowa	North Carolina	Washington
Kansas	North Dakota	West Virginia
Kentucky	Northern Mariana Islands	Wisconsin
Louisiana	Oklahoma	
Maine	Oregon	

MEDICAID AND THE POOR

In 1992, Medicaid covered 11.2 percent of the total U.S. population (excluding institutionalized persons) and 47 percent of those with incomes below the Federal poverty level. Because categorical eligibility requirements for children are less restrictive than those for adults, poor children are much more likely to receive coverage. Table 18-12 shows Medicaid eligibility by age and income status in 1992, as reported in the March 1993 Current Population Survey (CPS) conducted by the Census Bureau. Note that persons shown

as receiving Medicaid may have had other health coverage as well. Nearly all the elderly, for example, have Medicare and/or private coverage.

Children under age 6 with family incomes below poverty are most likely to be covered. Coverage rates drop steadily with age and income until age 65.

TABLE 18-12.—MEDICAID COVERAGE BY AGE AND INCOME STATUS, 1992

[All numbers are in thousands]

Age	Medicaid	Total	Percent with Medicaid
Poor:			
0 to 5	4,458	6,046	73.7
6 to 18	5,419	9,220	58.8
19 to 44	4,988	13,201	37.8
45 to 64	1,349	4,431	30.4
65 and over	1,205	3,983	30.2
Total	17,419	36,880	47.2
Family income between 100 and 133 percent of poverty:			
0 to 5	726	1,693	42.9
6 to 18	865	3,246	26.6
19 to 44	968	5,708	17.0
45 to 64	412	2,176	18.9
65 and over	564	3,004	18.8
Total	3,534	15,827	22.3
Family income between 133 percent and 185 percent of poverty:			
0 to 5	737	2,690	27.4
6 to 18	706	5,251	13.4
19 to 44	891	9,847	9.0
45 to 64	293	3,619	8.1
65 and over	426	4,644	9.2
Total	3,053	26,051	11.7
Family income greater than 185 percent of poverty:			
0 to 5	888	13,079	6.8
6 to 18	966	28,879	3.3
19 to 44	1,363	74,489	1.8
45 to 64	468	39,524	1.2
65 and over	720	19,240	3.7
Total	4,405	175,211	2.5
All individuals:			
0 to 5	6,809	23,508	29.0
6 to 18	7,956	46,596	17.1
19 to 44	8,210	103,245	8.0
45 to 64	2,522	49,750	5.1
65 and over	2,914	30,870	9.4
Total	28,411	253,969	11.2

Source: Current Population Survey (CPS), Annual March Income Supplement. Table prepared by CRS. The table excludes persons in institutions and approximately 300,000 children under age 15 whose income was not reported. The Medicaid counts are lower than those reported by HCFA, because some beneficiaries fail to report their coverage on the CPS. Some may also underreport their income. In addition, the income used to determine poverty status in this table includes cash welfare, while Medicaid eligibility is based on income prior to the receipt of welfare benefits.

SERVICES

States are required to offer the following services to categorically needy recipients under their Medicaid programs: inpatient and outpatient hospital services; laboratory and X-ray services; nursing facility (NF) services for those over age 21; home health services for those entitled to NF care; early and periodic screening, diagnosis, and treatment (EPSDT) for those under age 21; family planning services and supplies; physicians' services, and nurse-midwife services. OBRA 1989 required States to provide ambulatory services offered by federally qualified health centers, effective April 1, 1990, and services furnished by certified family or pediatric nurse practitioners, effective July 1, 1990. States may also provide additional medical services such as drugs, eyeglasses, inpatient psychiatric care for individuals under age 21 or over 65 (see table 25). OBRA 1990 added two new optional services: home and community-based services for the functionally disabled elderly and community supported living arrangement services for the developmentally disabled. Total expenditures under these services are capped. States are permitted to establish limitations on the amount of care provided under a service category (such as limiting the number of days of covered hospital care or number of physicians' visits). Certain services to children may not be limited.

Federal law establishes the following requirements for coverage of the medically needy: (1) if a State provides medically needy coverage to any group it must provide ambulatory services to children and prenatal and delivery services for pregnant women; (2) if a State provides institutional services for any medically needy group it must also provide ambulatory services for this population group; and (3) if the State provides medically needy coverage for persons in intermediate care facilities for the mentally retarded (ICF/MRs) or institutions for mental diseases, it must offer to all groups covered in its medically needy program the same mix of institutional and noninstitutional services as required under prior law (that is, either all of the mandatory services or alternatively the care and services listed in 7 of the 25 paragraphs in the law defining covered services).

FINANCING

The Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula which is adjusted annually. The matching rate, which is inversely related to a State's per capita income, can range from 50 percent to 83 percent though currently the highest rate is 78.85 percent. Federal matching for the territories is set at 50 percent with a maximum dollar limit placed on the amount each territory can receive. The Federal share of administrative costs is 50 percent for all States except for certain items where the authorized rate is higher.

REIMBURSEMENT POLICY

States establish their own service reimbursement policies within general Federal guidelines. OBRA 1989 codified the regulatory requirement that payments must be sufficient to enlist enough providers so that covered services will be available to Medicaid bene-

ficiaries at least to the extent they are available to the general population in a geographic area. Beginning April 1, 1990, States are required to submit to the Secretary their payment rates for pediatric and obstetrical services along with additional data that will assist the Secretary in evaluating the State's compliance with this requirement.

Until 1980, States were required to follow Medicare rules in paying for institutional services. The Boren amendment, enacted with respect to nursing homes in 1980 and extended to hospitals in 1981, authorized States to establish their own payment systems, as long as rates were reasonable and adequate to meet the costs of efficiently and economically operated facilities. Rates for hospitals must also be sufficient to assure reasonable access to inpatient services of adequate quality. A Supreme Court ruling in 1990, *Wilder v. Virginia Hospital Association*, affirmed that hospitals have the right under this rule to seek Federal court review of State reimbursement levels. Suits alleging inadequate hospital and nursing home payment have been filed in a number of States.

In addition to meeting general adequacy tests, State hospital reimbursement systems must provide for additional payments to facilities serving a disproportionate share of low-income patients. Unlike the comparable Medicare payments, Medicaid payments must follow a formula that considers a hospital's charity patients as well as its Medicaid caseload.

OBRA 1990 established new rules for Medicaid reimbursement of prescription drugs. The law denies Federal matching funds for drugs manufactured by a firm that has not agreed to provide rebates. Under amendments made by the Veterans Health Care Act of 1992, a manufacturer is not deemed to have a rebate agreement unless the manufacturer has entered into a master agreement with the Secretary of Veterans Affairs. Rebate amounts vary depending on the nature of the drug. The minimum rebate is 11 percent of the average price. OBRA 1990 established a 4-year moratorium on reductions in most payment rates for pharmacists.

Practitioners and providers are required to accept payments under the program as payment in full for covered services except where nominal cost-sharing charges may be required. States may generally impose such charges with certain exceptions. They are precluded from imposing such charges on services for children under 18, services related to pregnancy, family planning or emergency services, HMO services for the categorically needy, and services provided to NF inpatients who are required to spend all of their income for medical care except for a personal needs allowance.

ADMINISTRATION

Medicaid is a State-administered program. At the Federal level, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services is responsible for overseeing State operations.

Federal law requires that a single State agency be charged with administration of the Medicaid program. Generally, that agency is either the State welfare agency, the State health agency, or the umbrella human resources agency. The single State agency may

contract with other State entities to conduct some program functions. Further, States may process claims for reimbursement themselves or contract with fiscal agents or health insuring agencies to process these claims.

RECENT LEGISLATIVE CHANGES

The following is a summary of the major Medicaid changes enacted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Public Law 101-508:

1. *Reimbursement for prescribed drugs.*—The law requires manufacturers of prescription drugs to provide rebates to State Medicaid programs. States will be required to cover all the drugs manufactured by a firm entering into a rebate agreement. The minimum rebate is 10 percent of the average manufacturer price for the product. Beginning in 1993, States are required to have prospective (i.e., point-of-sale) and retrospective drug utilization review (DUR) programs, to assure that prescriptions are appropriate and medically necessary. Until the end of 1993, enhanced Federal matching payments are provided for State administrative costs related to the rebate and DUR programs. The law establishes a 4-year moratorium on reductions in most payment rates for pharmacists.

2. *Required payment of premiums and cost-sharing for enrollment under group health plans where cost-effective.*—Effective January 1, 1991, the law requires States to pay premiums for group health plans for which Medicaid beneficiaries are eligible, when it is cost-effective to do so. Guidelines for determining cost-effectiveness are to be issued by the Secretary. States will pay any cost-sharing required by a plan and continue to furnish any Medicaid benefits not covered under the plan. Providers under group health plans will be required to accept plan payment as payment in full for Medicaid enrollees.

3. *Protection of low-income Medicare beneficiaries.*—The law accelerates phase-in of the requirement that States pay Medicare premiums and cost-sharing for QMBs, Medicare beneficiaries with incomes below 100 percent of the Federal poverty level; for all but 5 States, the requirement was effective January 1, 1991. All States must pay part B premiums (but not part A premiums or cost-sharing) for beneficiaries with incomes below 110 percent of the poverty level in 1993 and below 120 percent in 1995.

4. *Child health provisions.*—Effective July 1, 1991, all States are required to cover children under age 19 who were born after September 30, 1983, and whose family income is below 100 percent of the Federal poverty level. States are required to accept Medicaid applications for mothers and children at locations other than welfare offices, and are required to continue benefits for pregnant women until 2 months after the end of the pregnancy, and for infants through the first year of life. States are required to make additional payments for outlier cases and are prohibited from imposing durational limits on coverage for patients who are under age 1 in any hospital or under age 6 in a disproportionate share hospital.

5. *Home and community-based care as optional service.*—The law permits States to provide home and community-based services to functionally disabled Medicaid beneficiaries aged 65 or over, effec-

tive the later of July 1, 1991, or 30 days after the publication of interim rules. States will be permitted to limit eligibility for the services without waivers and thus to provide the services without meeting cost-effectiveness tests. Federal matching payments cannot exceed 50 percent of what it would have cost to provide Medicare nursing facility care to the same group of beneficiaries. Total Federal expenditures will be limited to \$580 million over the period fiscal years 1991 to 1995.

6. *Community supported living arrangements.*—The law permits between two and eight States to provide community supported living arrangement services to developmentally disabled individuals who live with their families or in small community residential settings, effective the later of July 1, 1991, or 30 days after the publication of interim rules. Services will include personal assistance, training and habilitation, and other services needed to help with activities of daily living. Total Federal expenditures will be limited to \$100 million over the period fiscal years 1991 to 1995.

7. *Payments for COBRA continuation coverage.*—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272) provides that employees or dependents leaving an employee health insurance group in a firm with 20 or more employees must be offered an opportunity to continue buying insurance through the group for 18 to 36 months (depending on the reason for leaving the group). OBRA 1990 permits State Medicaid programs to pay for COBRA continuation coverage, when it is cost effective to do so, effective January 1, 1991. States may pay premiums for individuals with incomes below 100 percent of poverty and resources less than twice the SSI limit who are eligible for continuation coverage under a group health plan offered by an employer with 75 or more employees.

8. *Miscellaneous.*—The law establishes demonstration projects in three to four States to test the effect of providing Medicaid to families with incomes below 150 percent of the Federal poverty level that do not meet categorical eligibility requirements, and projects in two States to provide Medicaid coverage for early intervention services for HIV-infected individuals who do not meet disability criteria. The law also includes new measures to ensure the quality of physician services under Medicaid, technical corrections in nursing home reform provisions, and numerous other technical and miscellaneous amendments.

The following is a summary of the major changes enacted in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234.

1. *Voluntary contributions and provider-specific taxes.*—The law caps Federal matching payments for State Medicaid spending that is financed with revenues from provider donations or taxes. Generally effective January 1, 1992, before the Federal share is computed, a State's expenditures for Medicaid are reduced by revenues received by a State or local government from provider-related donations, and health care related taxes that are not broad based. Broad based taxes are those that are uniformly imposed on all providers in a class, or all business in a class furnished by the providers. States with non-broad based taxes in effect or approved as of November 22, 1991, are permitted to continue them temporarily,

but the taxes may not be increased. States with voluntary contribution programs in effect or reported as of September 30, 1991, for States' fiscal year 1992, may continue them temporarily but may not increase them. During fiscal year 1993-95, Federal matching funds for revenue from voluntary contributions, provider specific taxes, and broad based taxes will be limited to the greater of 25 percent of the State share of Medicaid expenditures or the amount of donations and taxes collected in the State in fiscal year 1992.

Federal matching funds are allowable for certain donations. These are bona fide provider donations that are not related to Medicaid payments to the provider, and donations in the form of payment for outstationing Medicaid eligibility workers. Beginning in fiscal year 1993, the latter type of donations will be limited to 10 percent of a State's Medicaid administrative costs.

2. *Payments for disproportionate share hospitals.*—The law places an aggregate national cap of 12 percent of Medicaid expenditures on payment adjustments for disproportionate share hospitals (DSH). Beginning with fiscal year 1993, a national DSH payment limit is projected, and each State receives a DSH allotment for the fiscal year; Federal matching payments will be denied for DSH payments that exceed a State's annual allotment. For the part of fiscal year 1992 beginning on or after January 1, 1992, Federal matching payments will be made only for DSH adjustments paid in accordance with a State plan in effect or submitted by September 30, 1991, or November 26, 1991, if the State has used specific criteria to designate a hospital as DSH. Higher payments are permitted if necessary to meet the minimum adjustments required by Medicaid law.

Two 1991 acts concern enrollment in two health maintenance organizations. The law specifies that no more than 75 percent of the enrollees of an HMO may be Medicaid or Medicare beneficiaries. Public Law 102-276 authorized a waiver of this requirement for the Dayton Area Health Plan. Public Law 102-317 authorized a similar waiver for the Tennessee Primary Care Network.

The following is a summary of major Medicaid changes enacted in the Veterans Health Care Act of 1992, Public Law 102-585, pertaining to Medicaid reimbursement policies for prescription drugs.

1. *Calculation of best price.*—The law excludes certain prices from calculation of best price (the lowest price available from a manufacturer) for Medicaid drug rebates. The law excludes the prices charged to the Indian Health Service, the Department of Veterans Affairs, veterans' State homes, the Department of Defense, the Public Health Service and certain private and nonprofit hospitals, as well as any prices charged under the Federal Supply Schedule of the General Services Administration or under State pharmaceutical assistance programs.

2. *Rebate amounts.*—The law changes the minimum basic rebates for brand name drugs to 15.7 percent of the average manufacturer price (AMP) in calendar year 1993, 15.4 percent of the AMP in 1994, 15.2 percent of the AMP in 1995, and 15.1 percent of the AMP thereafter. In each calendar year, the basic rebate is the greater of the percentage stated, or the difference between the AMP and the best price.

The following is a summary of major Medicaid changes enacted in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), Public Law 103-66.

1. *Medicaid Fraud Control Units.*—The law changed the State option to a requirement that each State operate a Medicaid fraud and abuse control unit unless the State demonstrates that effective operation of a unit would not be cost-effective and that, in the absence of a unit, beneficiaries will be protected from abuse and neglect.

2. *Prescription drug formularies.*—States have been prohibited from using drug formularies (lists of covered and excluded drug products) and from imposing restrictions on new drug products for 6 months after a drug is approved by the Food and Drug Administration. Effective October 1, 1993, OBRA 93 allows States to use formularies to cover only the State's designated drug(s) in a class of therapeutic alternatives and impose certain requirements on prescriptions for new drugs.

3. *Asset and trust provisions.*—Some individuals must spend their assets down to a State-established level before Medicaid pays for nursing facility and other medical care. To try to ensure that these persons apply their assets to the cost of their care and do not give them away in order to gain Medicaid eligibility sooner than they otherwise would, Medicaid prohibits persons from transferring assets for less than fair market value.

OBRA 93 amends Medicaid law to close "loopholes" that allow individuals to shelter or divest assets in order to become eligible for Medicaid-covered long-term care. States are required to provide for a delay in Medicaid eligibility for institutionalized persons or their spouses who dispose of assets for less than fair market value. A transfer that occurred during the 36-month period prior to an application for coverage would trigger a period of ineligibility beginning with the month the assets were transferred. Under the OBRA 93 amendments, the period of ineligibility is determined by comparing the cost of care and the fair market value of the assets transferred.

The law requires that States seek recovery of Medicaid expenditures from the estate of a deceased beneficiary who received certain Medicaid benefits. Amounts paid by Medicaid for nursing facility services, home and community-based care, and related hospital and prescription drug services must be recovered from the estates of individuals who were over age 55 when such services were received.

OBRA 93 provides for exemptions to these asset transfer and recovery provisions if application of the law would result in "undue hardship" according to criteria established by the Secretary.

4. *Child support enforcement.*—A child who is covered by Medicaid may also be covered by private health insurance that is carried by a noncustodial parent. To improve medical support for children, Medicaid law is amended to mandate that States have laws in effect to require the cooperation of employers and insurers in obtaining parental coverage.

5. *Disproportionate share hospitals (DSH).*—OBRA 93 law prohibits States from designating a hospital as a DSH unless Medicaid beneficiaries account for at least 1 percent of the hospital's inpatient days. In addition, the law requires that DSH payments to a

State or locally owned or operated facility cannot exceed the costs the facility incurs in furnishing inpatient or outpatient service to Medicaid beneficiaries or uninsured patients. For this purpose, a facility's cost is net of payments received from Medicaid (other than DSH payments) and from uninsured individuals.

6. *Physician referral.*—OBRA 93 limits Medicaid payments for designated health services (including clinical laboratory, physical and occupational therapy, radiology, or other diagnostic services, home health and other services) if such services are furnished upon referral from a physician who has a specified financial relationship with the provider furnishing the service.

7. *Childhood immunization.*—OBRA 93 established a new entitlement program under which States are entitled to receive vaccines purchased by the Federal government for federally eligible children up to age 18. Providers registered in a State's immunization program are entitled to receive free vaccines for children covered under the new law. Children eligible to receive federally-purchased vaccines are Medicaid-eligible, American Indian or Alaska Native, children whose health insurance does not cover the cost of vaccines, and children who receive immunization at federally qualified health centers or rural health clinics.

8. *Tuberculosis-related services.*—OBRA 93 permits States to provide Medicaid coverage for outpatient tuberculosis-related services to tuberculosis-infected individuals who meet the income and resource limits that apply to disabled persons.

PROGRAM DATA

Under current law, Federal Medicaid outlays are projected to reach \$96.2 billion in fiscal year 1995, a 12 percent increase over the \$85.8 billion projected for fiscal year 1994. Medicaid program data are presented in the following tables 18–13 to 18–24.

TABLE 18-13.—HISTORY OF MEDICAID PROGRAM COSTS

Fiscal year	Total		Federal		State	
	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase	Dollars (in millions)	Percent increase
1966 ¹	1,658	.....	789	.....	869	.....
1967 ¹	2,368	42.8	1,209	53.2	1,159	33.4
1968 ¹	3,686	55.7	1,837	51.9	1,849	59.5
1969 ¹	4,166	13.0	2,276	23.9	1,890	2.2
1970 ¹	4,852	16.5	2,617	15.0	2,235	18.3
1971	6,176	27.3	3,374	28.9	2,802	25.4
1972 ²	8,434	36.6	4,361	29.3	4,074	45.4
1973	9,111	8.0	4,998	14.6	4,113	1.0
1974	10,229	12.3	5,833	16.7	4,396	6.9
1975	12,637	23.5	7,060	21.0	5,578	26.9
1976	14,644	15.9	8,312	17.7	6,332	13.5
TQ ³	4,106	NA	2,354	NA	1,752	NA
1977	17,103	⁴ 16.8	9,713	⁴ 16.9	7,389	⁴ 16.7
1978	18,949	10.8	10,680	10.0	8,269	11.9
1979	21,755	14.8	12,267	14.9	9,489	14.8
1980	25,781	18.5	14,550	18.6	11,231	18.4
1981	30,377	17.8	17,074	17.3	13,303	18.4
1982	32,446	6.8	17,514	2.6	14,931	12.2
1983	34,956	7.7	18,985	8.4	15,971	7.0
1984	37,569	7.5	20,061	5.7	17,508	9.6
1985 ⁵	40,917	8.9	⁶ 22,655	12.9	⁶ 18,262	4.3

1986	44,851	9.6	24,995	10.3	19,856	8.7
1987	49,344	10.0	27,435	9.8	21,909	10.3
1988	54,116	9.7	30,462	11.0	23,654	8.0
1989	61,246	13.2	34,604	13.6	26,642	12.6
1990	72,492	18.4	41,103	18.8	31,389	17.8
1991	91,519	26.2	52,532	27.8	38,987	24.2
1992	118,166	29.1	67,827	29.1	50,339	29.1
1993	132,010	11.7	75,774	11.7	56,236	11.7
1994 (current law estimate)	152,371	15.4	87,156	15.0	65,215	16.0
1995 (current law estimate)	168,806	10.8	96,388	10.6	72,418	11.0

¹ Includes related programs which are not separately identified, though for each successive year a larger portion of the total represents Medicaid expenditures. As of Jan. 1, 1970, Federal matching was only available under Medicaid.

² Intermediate care facilities (ICFs) transferred from the cash assistance programs to Medicaid effective January 1, 1972. Data for prior periods do not include these costs.

³ Transitional quarter (beginning of Federal fiscal year moved from July 1 to Oct. 1).

⁴ Represents increase over fiscal year 1976, i.e., five calendar quarters.

⁵ Includes transfer of function of State fraud control units to Medicaid from Office of Inspector General.

⁶ Temporary reductions in Federal payments authorized for fiscal years 1982-84 were discontinued in fiscal year 1985.

Note: Totals may not add due to rounding.

Source: "Budget of the U.S. Government" fiscal years 1969-95, and Health Care Financing Administration, Division of Budget.

TABLE 18-14.—UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972-92
[Number in thousands]

Fiscal year	Total	Aged 65 or over	Blindness	Permanent and total disability	Dependent children under age 21	Adults in families with dependent children	Other Title XIX
1972	17,606	3,318	108	1,625	7,841	3,137	1,576
1973	19,622	3,496	101	1,804	8,659	4,066	1,495
1974	21,462	3,732	135	2,222	9,478	4,392	1,502
1975	22,007	3,615	109	2,355	9,598	4,529	1,800
1976	22,815	3,612	97	2,572	9,924	4,774	1,836
1977 ¹	22,832	3,636	92	2,710	9,651	4,785	1,959
1978	21,965	3,376	82	2,636	9,376	4,643	1,852
1979	21,520	3,364	79	2,674	9,106	4,570	1,727
1980 ²	21,605	3,440	92	2,819	9,333	4,877	1,499
1981 ²	21,980	3,367	86	2,993	9,581	5,187	1,364
1982 ²	21,603	3,240	84	2,806	9,563	5,356	1,434
1983 ²	21,554	3,371	77	2,844	9,535	5,592	1,129
1984 ²	21,607	3,238	79	2,834	9,684	5,600	1,187
1985 ²	21,814	3,061	80	2,937	9,757	5,518	1,214
1986 ²	22,515	3,140	82	3,100	10,029	5,647	1,362
1987 ²	23,109	3,224	85	3,296	10,168	5,599	1,418
1988 ²	22,907	3,159	86	3,401	10,037	5,503	1,343
1989 ²	23,511	3,132	95	3,496	10,318	5,717	1,175
1990	25,255	3,202	83	3,635	11,220	6,010	1,105
1991	28,280	3,359	85	3,983	13,415	6,778	658
1992	30,926	3,742	84	4,378	15,104	6,954	664

¹ Fiscal Year 1977 began in October 1976 and was the first year of the new Federal fiscal cycle. Before 1977, the fiscal year began in July.

² Beginning in fiscal year 1980, recipients' categories do not add to the unduplicated total due to the small number of recipients that are in more than one category during the year.

Source: HCFA, BOMS, OPS, Division of Medicaid Statistics, Fiscal Years 1972-91, Office of the Actuary, Fiscal years 1993 and beyond. December 22, 1993.

TABLE 18-15.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1992

State	Total re- cipients ¹	Aged	Blind	Disabled	AFDC children	AFDC adults	Other Title XIX
Alabama	466,918	69,882	1,586	100,187	198,418	91,022	4,574
Alaska	57,540	3,388	81	4,633	32,479	16,959	0
Arizona	402,212	23,258	693	43,696	236,155	98,410	0
Arkansas	320,875	51,489	1,289	67,511	97,549	70,969	32,068
California	4,485,743	491,686	24,306	609,612	2,008,346	1,256,752	60,350
Colorado	258,690	30,621	157	34,254	125,026	65,065	3,567
Connecticut	316,278	55,102	281	37,836	146,719	76,340	0
Delaware	60,696	5,358	105	8,461	31,687	13,558	1,325
District of Columbia	108,514	11,541	5	16,731	55,304	24,812	121
Florida	1,537,926	186,180	3,403	204,373	811,973	294,157	37,840
Georgia	863,670	99,625	4,722	139,095	412,087	198,838	1,112
Hawaii	99,666	13,817	15	10,239	47,368	26,111	0
Idaho	86,924	8,783	52	12,480	44,224	20,758	627
Illinois	1,313,140	105,955	1,359	213,951	669,474	303,931	18,470
Indiana	506,829	52,433	1,172	70,558	252,765	127,264	0
Iowa	278,828	38,333	619	39,000	116,983	68,277	14,868
Kansas	226,991	25,268	115	27,057	108,272	53,397	0
Kentucky	583,089	61,052	1,924	113,316	257,105	136,641	1,882
Louisiana	702,264	96,403	1,797	111,025	345,662	147,377	0
Maine	162,441	22,332	207	27,281	69,082	37,367	5,567
Maryland	377,075	49,749	306	61,045	182,487	77,702	5,786
Massachusetts	686,235	105,314	10,362	122,202	295,507	152,849	0
Michigan	1,129,023	84,998	2,212	167,448	565,350	309,015	0
Minnesota	406,491	57,801	461	41,697	195,047	99,891	11,594
Mississippi	486,861	65,989	1,634	92,784	321,010	3,973	1,471
Missouri	554,477	78,916	1,127	76,338	258,573	137,413	2
Montana	60,186	8,115	76	12,618	20,690	3,434	13,740
Nebraska	150,791	19,939	223	17,612	67,553	31,793	13,671
Nevada	77,525	9,091	415	9,998	36,551	18,840	1,584
New Hampshire	71,179	13,882	486	9,442	33,815	13,224	0

TABLE 18-15.—MEDICAID RECIPIENTS BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1992—Continued

State	Total re- cipients ¹	Aged	Blind	Disabled	AFDC children	AFDC adults	Other Title XIX
New Jersey	697,083	78,663	1,200	107,949	327,381	175,240	0
New Mexico	211,805	14,106	560	25,446	128,312	43,381	0
New York	2,557,701	339,784	3,732	370,858	1,141,711	516,124	185,492
North Carolina	785,043	120,599	1,047	91,385	368,882	203,130	0
North Dakota	57,068	10,713	28	7,067	24,213	12,488	2,189
Ohio	1,442,289	152,083	957	162,159	777,458	345,594	4,038
Oklahoma	360,039	55,955	670	42,863	178,902	80,951	698
Oregon	295,320	29,138	1,190	34,906	150,943	79,143	0
Pennsylvania	1,174,779	136,293	942	195,284	562,049	237,670	41,807
Rhode Island	213,388	39,660	521	40,936	87,193	43,452	1,629
South Carolina	431,083	72,339	1,812	67,685	198,972	90,212	63
South Dakota	64,230	9,751	149	10,045	31,097	13,188	0
Tennessee	785,231	93,455	2,574	156,723	367,193	153,950	11,336
Texas	2,024,554	265,254	3,921	189,471	1,100,136	465,772	0
Utah	137,264	8,814	117	14,305	72,860	39,726	24
Vermont	77,502	10,643	94	10,546	34,342	21,058	455
Virginia	515,064	78,411	1,146	76,752	244,340	114,415	0
Washington	568,673	50,639	365	81,049	232,246	156,546	46,259
West Virginia	308,034	31,609	272	49,168	131,024	93,117	2,844
Wisconsin	440,136	66,845	1,189	87,560	161,587	78,107	40,657
Wyoming	42,401	3,086	8	3,890	23,523	11,023	570
Puerto Rico	885,405	127,011	469	48,779	709,146	0	0
Virgin Islands	13,221	1,143	6	889	7,255	3,403	515
United States	30,027,764	3,614,140	83,684	4,328,527	14,387,625	6,950,426	568,280
All jurisdictions	30,926,390	3,742,294	84,159	4,378,195	15,104,036	6,953,829	568,795

¹ Total recipients include unknowns which are not reflected in this table.

Source: HCFA, BDMS, Office of Programs Systems, data from Division of Medicaid Statistics December 22, 1993.

TABLE 18-16.—MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1992

[In millions of dollars]

State	Total ex- pendi- tures ²	Aged	Blind	Disabled	AFDC children	AFDC adults	Other title XIX	Aged, blind and disabled as a per- cent of total exp.	AFDC children as a per- cent of total exp.
Alabama	1,056	352	4	392	148	149	9	70.9	14.0
Alaska	187	37	(1)	48	53	48	0	46.0	28.5
Arizona	209	13	1	63	96	35	0	37.3	45.8
Arkansas	885	266	6	367	87	85	74	72.2	9.9
California	8,692	2,251	96	2,983	1,309	1,860	129	61.3	15.1
Colorado	814	233	4	303	129	128	17	66.4	15.9
Connecticut	1,663	797	4	570	163	129	0	82.4	9.8
Delaware	219	62	1	96	32	25	3	72.3	14.7
District of Columbia	499	140	(1)	212	92	54	(1)	70.7	18.4
Florida	3,518	1,074	14	1,160	756	457	57	63.9	21.5
Georgia	2,149	538	28	735	356	471	1	60.6	16.6
Hawaii	270	112	(1)	64	44	48	0	65.4	16.3
Idaho	275	72	(1)	118	42	41	1	69.3	15.4
Illinois	4,070	872	9	1,995	651	486	56	70.7	16.0
Indiana	2,225	557	9	930	401	322	0	67.2	18.0
Iowa	855	238	2	332	119	133	29	67.0	13.9
Kansas	620	187	(1)	225	100	86	0	66.6	16.2
Kentucky	1,543	361	8	609	279	279	1	63.3	18.1
Louisiana	2,479	532	10	972	533	433	0	61.0	21.5
Maine	642	240	1	235	76	76	13	74.1	11.8
Maryland	1,612	445	2	644	276	193	52	67.7	17.1
Massachusetts	3,248	1,256	88	1,224	372	308	0	79.1	11.5
Michigan	2,802	652	10	1,232	459	449	0	67.6	16.4
Minnesota	1,750	631	6	631	196	183	21	77.1	11.2
Mississippi	881	264	5	317	289	2	4	66.5	32.8
Missouri	1,350	472	5	461	234	175	(1)	69.4	17.3
Montana	217	77	(1)	95	17	5	15	79.6	7.9
Nebraska	468	168	2	153	63	50	33	69.0	13.4
Nevada	282	64	3	100	49	52	7	59.4	17.4
New Hampshire	340	167	7	112	33	20	0	84.2	9.8
New Jersey	2,802	912	8	1,163	311	400	0	74.3	11.1

TABLE 18-16.—MEDICAID EXPENDITURES BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1992—Continued
[In millions of dollars]

State	Total ex- pendi- tures ²	Aged	Blind	Disabled	AFDC children	AFDC adults	Other title XIX	Aged, blind and disabled as a per- cent of total exp.	AFDC children as a per- cent of total exp.
New Mexico	478	93	4	160	148	73	0	53.8	30.9
New York	15,281	6,214	102	5,710	1,766	1,207	283	78.7	11.6
North Carolina	2,083	647	9	673	414	341	0	63.8	19.9
North Dakota	253	99	(¹)	98	30	22	2	78.2	11.9
Ohio	4,308	1,535	4	1,374	853	541	1	67.6	19.8
Oklahoma	1,004	288	2	299	272	141	1	58.7	27.1
Oregon	748	201	20	288	137	103	0	68.0	18.3
Pennsylvania	3,547	1,368	3	1,265	513	345	54	74.3	14.5
Rhode Island	774	283	3	346	72	64	6	81.6	9.3
South Carolina	1,151	329	6	414	218	184	(¹)	65.0	19.0
South Dakota	231	85	1	90	34	20	0	76.3	14.9
Tennessee	1,735	441	7	646	354	255	32	63.1	20.4
Texas	4,407	1,402	16	1,228	976	785	0	60.0	22.1
Utah	365	64	1	139	72	88	(¹)	55.8	19.6
Vermont	222	75	(¹)	93	22	30	1	75.6	10.1
Virginia	1,511	486	6	525	273	222	0	67.3	18.0
Washington	1,347	420	2	423	184	286	32	62.7	13.6
West Virginia	795	200	1	276	111	175	32	60.0	13.9
Wisconsin	1,677	663	8	693	124	102	62	81.4	7.4
Wyoming	114	34	(¹)	33	26	21	1	58.1	22.6
Puerto Rico	158	23	(¹)	9	127	0	0	19.9	80.1
Virgin Islands	5	1	(¹)	1	2	1	(¹)	35.2	34.6
United States	90,651	29,054	530	33,316	14,363	12,184	1,032	69.4	15.8
All jurisdictions	90,814	29,078	530	33,326	14,491	12,185	1,032	69.3	16.0

¹ Denotes expenditures of less than \$500,000.

² Total expenditures include unknowns which are not reflected in this table.

Source: HCFA, BDMS, Office of Programs Systems, data from Division of Medicaid Statistics, December 22, 1993.

TABLE 18-17.—TOTAL AND PER CAPITA MEDICAID PAYMENTS FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, PRELIMINARY ESTIMATES, FISCAL YEARS 1975, 1981 AND 1992

	1975			1981			1992			Percent change 1975-92
	Total amount (mil- lions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	Total amount (millions)	Percent of total	Per capita	
Categorically needy:										
Receiving cash payments	\$7,188	58.7	\$431	\$14,534	53.4	\$861	\$41,742	46.0	\$2,238	\$419.7
Aged	1,341	11.0	555	2,480	9.1	1,270	5,795	6.4	3,778	580.7
Blind	61	.5	717	109	.4	1,527	334	0.4	4,669	447.5
Disabled	2,042	16.7	1,094	5,616	20.6	2,490	19,863	21.9	6,097	872.7
AFDC children	1,850	15.1	222	3,002	11.0	361	8,376	9.2	891	352.8
Adults in AFDC families	1,895	15.5	478	3,328	12.2	769	7,374	8.1	1,682	289.1
Not receiving cash payments	1,753	14.3	1,261	4,736	17.4	2,641	16,064	17.7	4,243	236.5
Aged	1,275	10.4	2,331	3,143	11.6	5,273	7,085	7.8	11,658	455.7
Blind	12	.1	1,094	19	.1	2,785	80	0.1	15,310	566.7
Disabled	353	2.9	1,854	1,214	4.5	5,146	5,065	5.6	11,913	1,334.8
AFDC children	61	.5	152	153	.6	302	1,764	1.9	1,156	791.8
Adults in AFDC families	27	.2	144	87	.3	298	1,428	1.6	1,606	5,188.9
Other title XIX	25	.2	463	120	.4	734	643	0.7	1,927	2,472.0
Total, categorically needy	8,941	73.0	495	19,270	70.8	1,032	57,807	63.7	2,577	546.5
Medically needy:										
Aged	1,742	14.2	2,672	4,303	15.8	5,260	8,927	9.8	11,724	412.5
Blind	20	.2	1,472	27	.1	3,132	71	0.1	21,865	255.0
Disabled	657	5.4	2,202	2,471	9.1	4,924	5,243	5.8	13,876	698.0
AFDC children	274	2.2	324	353	1.3	460	1,592	1.8	943	481.0
Adults in AFDC families	140	1.1	368	348	1.3	613	1,265	1.4	1,930	803.6
Other title XIX	467	3.8	267	433	1.6	360	268	0.3	1,844	-42.6
Total, medically needy	3,301	27.0	838	7,935	29.2	2,145	17,367	19.1	4,782	426.1
Grand total	12,242	100.0	556	27,205	100.0	1,216	90,814	100.0	2,936	641.8
										428.1

Note: Totals may not add due to rounding. Fiscal year 1975 ends in June; fiscal years 1981 and 1988 end in September. Total includes other coverage groups and unknowns. Other categories not shown in the total for 1991 are: Other coverage pre-88, \$6,799; coverage from 88, \$4,070; and mass unknown, \$220.

Source: HCFA, BOMS, OPS, Division of Medicaid Statistics, December 22, 1993.

TABLE 18-18.—MEDICAID RECIPIENTS AND PAYMENTS BY BASIS OF ELIGIBILITY,
FISCAL YEAR 1992

	Amount (in millions)	Percent of total	Recipients (in thousands)	Percent of total	Per capita pay- ments
Age 65 and over	29,077.6	32.0	3,742.3	12.1	7,770.0
Blind	530.0	0.6	84.2	0.3	6,297.7
Disabled	33,325.8	36.7	4,378.2	14.2	7,611.8
Dependent children under age 21	14,491.0	16.0	15,104.0	48.8	959.4
Adults in families with dependent children	12,185.2	13.4	6,953.8	22.5	1,752.3
Other title XIX	1,031.9	1.1	568.8	1.8	1,814.3
Total	90,813.5	100.0	30,926.4	100.0	2,936.4

Note: Recipients and payments totals include unknowns which are not shown in this table.

Source: HCFA, BDMS, Office of Programs Systems. Data from Division of Medicaid Statistics, December 22, 1993.

TABLE 18-19.—MEDICAID PAYMENTS AND PER CAPITA PAYMENTS BY BASIS OF ELIGIBILITY, FISCAL YEARS 1975, 1981, AND 1984-92

[Amounts in millions of dollars]

	1975	1981	1984	1985	1986	1987	1988	1989	1990	1991	1992	Percent change, 1975- 92
Payments:												
In Nominal Dollars												
Age 65 and over	4,358	9,926	12,815	14,096	15,097	16,037	17,135	18,558	21,508	25,453	29,078	567.3
Blind	93	154	219	249	277	309	344	409	434	475	530	47.6
Disabled	3,052	9,301	11,758	13,203	14,635	16,507	18,250	20,476	23,969	27,798	33,326	991.8
Dependent children under age 21	2,186	3,508	3,979	4,414	5,135	5,508	5,848	6,892	9,100	11,690	14,491	562.9
Adults in families with dependent children	2,062	3,763	4,420	4,746	4,880	5,592	5,883	6,897	8,590	10,439	12,185	491.0
Other title XIX	492	552	700	798	980	1,078	1,198	1,137	1,051	973	1,032	109.9
Total	12,242	27,204	33,891	37,508	41,005	45,050	48,710	54,500	64,859	77,048	90,814	641.8
Per capita payment:												
Age 65 and over	1,205	2,948	3,957	4,605	4,808	4,975	5,425	5,926	6,717	7,577	7,770	544.6
Blind	850	1,784	2,766	3,104	3,401	3,644	4,005	4,319	5,212	5,572	6,298	641.0
Disabled	1,296	3,108	4,149	4,496	4,721	5,008	5,366	5,858	6,595	6,979	7,612	487.3
Dependent children under age 21	228	366	411	452	512	542	583	668	811	871	959	321.2
Adults in families with dependent children	455	725	789	860	864	999	1,069	1,206	1,429	1,540	1,752	248.9
Other title XIX	273	405	590	658	719	761	891	967	1,062	1,732	1,814	564.2
Total, per capita payment	556	1,238	1,569	1,719	1,821	1,949	2,126	2,318	2,568	2,725	2,936	427.9

TABLE 18-19.—MEDICAID PAYMENTS AND PER CAPITA PAYMENTS BY BASIS OF ELIGIBILITY, FISCAL YEARS 1975, 1981, AND 1984-92—Continued
[Amounts in millions of dollars]

	1975	1981	1984	1985	1986	1987	1988	1989	1990	1991	1992	Percent change, 1975- 92
In Constant 1992 Dollars												
Payments:												
Age 65 and over	11,723	15,584	17,300	18,466	19,173	19,886	20,391	21,156	23,229	26,217	29,078	148.0
Blind	250	242	296	326	352	383	409	466	469	489	530	112.0
Disabled	8,210	14,603	15,873	17,296	18,586	20,469	21,718	23,343	25,887	28,632	33,326	305.9
Dependent children under age 21	5,880	5,508	5,372	5,782	6,521	6,830	6,959	7,857	9,828	12,041	14,491	146.4
Adults in families with dependent children	5,547	5,908	5,967	6,217	6,198	6,934	7,001	7,863	9,277	10,752	12,185	119.7
Other title XIX	1,323	867	945	1,045	1,245	1,337	1,426	1,296	1,135	1,002	1,032	-22.0
Total ¹	32,931	42,710	45,753	49,135	52,076	55,862	57,965	62,130	70,048	79,359	90,814	175.8
Per capita payment:												
Age 65 and over	3,241	4,628	5,342	6,033	6,106	6,169	6,456	6,756	7,254	7,804	7,770	139.7
Blind	2,287	2,801	3,734	4,066	4,319	4,519	4,766	4,924	5,629	5,739	6,298	173.4
Disabled	3,486	4,880	5,601	5,890	5,996	6,210	6,386	6,678	7,123	7,188	7,612	118.4
Dependent children under age 21	613	575	555	592	650	672	694	762	876	897	959	56.4
Adults in families with dependent children	1,224	1,338	1,065	1,127	1,097	1,239	1,272	1,375	1,543	1,586	1,752	43.1
Other title XIX	734	636	797	862	913	944	1,060	1,102	1,147	1,784	1,814	147.1
Total, per capita payment	1,496	1,944	2,118	2,252	2,313	2,417	2,530	2,643	2,773	2,807	2,936	96.3

¹ Data exclude unknowns.

Note: Total may not add due to rounding. Fiscal year 1975 ends in June; all other fiscal years end in September. Nominal dollars converted to constant dollars using CPI-U price index. Total expenditures includes other coverage groups and unknowns for fiscal year 1992.

Source: HCFA, BDMs, OPS, Division of Medicaid Statistics, December, 1993, and Congressional Research Service.

TABLE 18-20.—MEDICAID PAYMENTS BY SERVICE CATEGORY, FISCAL YEARS 1975, 1981, 1990-92

[Amounts in millions of constant 1990 dollars]

	1975		1981		1990		1992		Average annual percent change 1975-92
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent of total	
Inpatient hospital	\$9,396	30.9	\$11,693	29.7	\$18,388	28.4	\$23,743	28.3	5.6
General	8,389	27.6	10,423	26.4	16,674	25.7	21,715	25.9	5.8
Mental	1,007	3.3	1,271	3.2	1,714	2.6	2,029	2.4	4.2
Skilled nursing facilities	16,052	19.9	5,846	14.8	8,026	12.4	21,752	25.9	7.8
Intermediate care facilities	5,632	18.5	10,870	27.6	17,021	26.2	(¹)	(¹)	(¹)
Intermediate care facilities for the mentally retarded	945	3.1	4,341	11.0	7,354	11.3	7,853	9.4	2.0
Other	4,687	15.4	6,530	16.6	9,667	14.9	(¹)	.....	(¹)
Physician	3,046	10.0	3,044	7.7	4,018	6.2	5,638	6.7	3.7
Dental	843	2.8	787	2.0	593	0.9	786	0.9	-0.4
Other practitioner	316	1.0	330	0.8	372	0.6	497	0.6	2.7
Outpatient hospital	927	3.0	2,041	5.2	3,324	5.1	4,877	5.8	10.3
Clinic	967	3.2	540	1.4	1,688	2.6	2,604	3.1	6.0
Lab and X-ray	313	1.0	213	0.5	721	1.1	956	1.1	6.8
Home health	174	0.6	620	1.6	3,404	5.2	4,514	5.4	21.1
Prescribed drugs	2,026	6.7	2,224	5.6	4,420	6.8	6,250	7.4	6.9
Family planning	167	0.5	201	0.5	265	0.4	462	0.6	6.2
Early and periodic screening ²	(²)	0.0	97	0.2	198	0.3	478	0.6	(¹)
Rural health clinic ²	(²)	0.0	6	0.0	34	0.1	125	0.1	(¹)
Other	579	1.9	897	2.3	2,385	3.7	3,317	4.0	10.8
Total	30,440	100.0	39,414	100.0	64,859	100.0	83,904	100	6.1

¹ Prior to fiscal year 1991, there were two categories of Medicaid nursing home care: skilled nursing facilities or intermediate nursing facilities. ² 1975 data not available. Note: Totals may not add due to rounding. Fiscal year 1975 ends in June; all other fiscal years end in September. Spending amounts put in constant dollars using the Consumer Price Index (CPI-U). Data exclude unknowns. Source: HCFA, BDMS, Office of Programs Systems, Data from Division of Medicaid Statistics, December 22, 1993.

TABLE 18-21.—MEDICAID RECIPIENTS BY SERVICE CATEGORY, FOR FISCAL YEARS 1975, 1981, 1989-92

[In thousands]

	Fiscal year—					
	1975	1981	1989	1990	1991	1992
Inpatient hospital:						
General	3,432	3,703	4,171	4,593	5,137	5,768
Mental	67	90	90	92	5,072	77
Nursing facilities ¹	1,312	1,385	1,452	1,461	1,499	1,573
Intermediate care facilities for the mentally retarded	69	151	148	147	146	151
Physician	15,198	14,403	15,686	17,078	19,321	21,627
Dental	3,944	5,173	4,214	4,552	5,209	5,700
Other practitioner	2,673	3,582	3,555	3,873	4,282	4,711
Outpatient hospital	7,437	10,018	11,344	12,370	14,137	15,120
Clinic	1,086	1,755	2,391	2,804	3,511	4,115
Laboratory & X ray	4,738	3,822	7,759	8,959	10,505	11,804
Home health	343	402	609	719	813	925
Prescribed drugs	14,155	14,256	15,916	17,294	19,602	22,030
Family planning	1,217	1,473	1,564	1,752	2,185	2,550
Early and periodic screening	(²)	1,969	2,524	2,952	3,957	4,982
Rural health clinics	(²)	81	166	224	405	743
Other	2,911	2,344	4,583	5,126	5,957	6,702
Unduplicated total	22,007	21,980	23,511	25,255	28,280	30,926

¹ Prior to fiscal year 1991, there were 2 categories of Medicaid nursing home care: skilled nursing facilities or intermediate nursing facilities.

² 1975 data not available.

Source: HCFA, BDMS, Office of Programs Systems, Division of Medicaid Statistics, December 1993.

TABLE 18-22.—MEDICAID MEDICAL VENDOR PAYMENTS BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE: FISCAL YEAR 1992

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Type of service	Aged	Blind	Disabled	AFDC		Other title XIX	Total
				Children	Adults		
Inpatient hospital services	1,869.9	86.1	8,927.4	6,554.6	5,480.8	466.1	23,384.9
Mental hospital services for the aged	908.5	.4	57.2	2.5	1.9	2.5	973.0
SNF/ICF mental health services for the aged	114.4	.0	5.1	0	0	0	119.5
Inpatient psychiatric services, age <22 .....	.3	.4	344.9	617.4	11.4	126.9	1,101.3
Intermediate care facility for the mentally retarded	519.6	130.9	7,837.9	37.6	14.2	4.7	8,545.0
Nursing facility services	19,596.5	107.5	3,762.0	15.1	45.7	8.3	23,535.0
Physician's services	399.6	24.1	1,485.0	1,946.9	2,138.9	94.1	6,088.5
Dental services	52.0	1.6	133.2	417.0	225.3	21.8	850.8
Other practitioners' services	66.1	2.6	199.3	136.7	126.0	7.1	537.8
Outpatient hospital services	310.8	19.4	1,600.9	1,736.1	1,521.3	84.4	5,272.8
Clinic services	174.1	18.0	1,555.6	572.5	414.8	79.0	2,814.0
Home health services	2,249.6	55.1	2,383.7	121.4	55.5	19.6	4,885.0
Family planning services	1.1	.5	25.8	57.3	408.5	6.6	499.7
Lab and x ray services	53.1	4.0	310.6	221.6	432.0	11.3	1,032.7
Prescribed drugs	2,190.9	48.9	2,873.7	806.3	805.2	37.0	6,762.0
Early and periodic screening .....	.1	.3	36.2	449.1	16.8	13.5	516.0
Rural health clinic services	4.4	.3	20.1	61.0	46.8	1.8	134.4
Other care	565.8	30.1	1,764.8	737.5	440.0	47.0	3,585.1
Unknown .....	.9	0	2.7	.4	.1	0	4.1
Total	29,077.6	530.0	33,325.8	14,491.0	12,185.2	1,031.9	90,641.6

[In millions of dollars]

TABLE 18-22.—MEDICAID MEDICAL VENDOR PAYMENTS BY BASIS OF ELIGIBILITY AND TYPE OF SERVICE: FISCAL YEAR 1992—Continued

Type of service	Aged	Blind	Disabled	AFDC		Other title XIX	Total
				Children	Adults		
				[In percent]			
Inpatient hospital services	6.4	16.2	26.8	45.2	45.0	45.2	25.8
Mental hospital services for the aged	3.1	.1	.2	0	0	.2	1.1
SNF/ICF mental health services for the aged .....	.4	0	0	0	0	0	.1
Inpatient psychiatric services, age <22	0	.1	1.0	4.3	.1	12.3	1.2
Intermediate care facility for the mentally retarded	1.8	24.7	23.5	.3	.1	.5	9.4
Nursing facility services	67.4	20.3	11.3	.1	.4	.8	26.0
Physician's services	1.4	4.5	4.5	13.4	17.6	9.1	6.7
Dental services .....	.2	.3	.4	2.9	1.8	2.1	.9
Other practitioners' services .....	.2	.5	.6	.9	1.0	.7	.6
Outpatient hospital services	1.1	3.7	4.8	12.0	12.5	8.2	5.8
Clinic services .....	.6	3.4	4.7	4.0	3.4	7.7	3.1
Home health services	7.7	10.4	7.2	.8	.5	1.9	5.4
Family planning services	0	.1	.1	.4	3.4	.6	.6
Lab and x ray services .....	.2	.8	.9	1.5	3.5	1.1	1.1
Prescribed drugs	7.5	9.2	8.6	5.6	6.6	3.6	7.5
Early and periodic screening	0	.1	.1	3.1	.1	1.3	.6
Rural health clinic services	0	.1	.1	.4	.4	.2	.1
Other care	1.9	5.7	5.3	5.1	3.6	4.6	4.0
Unknown	0	0	0	0	0	0	0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: HCFA, BDMS, Office of Programs Systems. Data from Division of Medicaid Statistics, December 22, 1993.

TABLE 18-23.—AVERAGE EXPENDITURE PER RECIPIENT BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1992

State	Total	Aged	Blind	Disabled	AFDC Children	AFDC Adults	Other title XIX
United States	\$3,019	\$8,039	\$6,332	\$7,697	\$998	\$1,753	\$1,816
All jurisdictions	2,936	7,770	6,298	7,612	959	1,752	1,814
Alabama	2,262	5,042	2,785	3,915	746	1,636	1,966
Alaska	3,248	10,934	6,068	10,467	1,640	2,806	0
Arizona	520	579	1,870	1,446	406	359	0
Arkansas	2,758	5,163	4,653	5,430	896	1,192	2,320
California	1,938	4,579	3,959	4,894	652	1,480	2,137
Colorado	3,145	7,618	25,435	8,845	1,033	1,961	4,691
Connecticut	5,258	14,458	14,836	15,070	1,111	1,691	0
Delaware	3,611	11,515	5,914	11,369	1,014	1,842	2,170
District of Columbia	4,595	12,171	5,493	12,658	1,658	2,187	2,603
Florida	2,288	5,770	4,133	5,676	932	1,553	1,495
Georgia	2,488	5,405	6,019	5,283	865	2,369	1,106
Hawaii	2,706	8,115	2,701	6,282	929	1,831	0
Idaho	3,159	8,154	6,587	9,481	955	1,979	1,534
Illinois	3,099	8,233	6,983	9,327	972	1,599	3,045
Indiana	4,390	10,627	7,635	13,181	1,585	2,531	0
Iowa	3,065	6,206	3,972	8,522	1,015	1,952	1,981
Kansas	2,730	7,410	4,076	8,322	928	1,619	0
Kentucky	2,647	5,908	4,139	5,374	1,085	2,039	582
Louisiana	3,530	5,514	5,470	8,755	1,541	2,937	0
Maine	3,950	10,751	3,918	8,604	1,094	2,044	2,420
Maryland	4,276	8,942	7,577	10,553	1,512	2,484	9,015
Massachusetts	4,733	11,925	8,495	10,015	1,259	2,015	0
Michigan	2,482	7,674	4,345	7,359	811	1,454	0
Minnesota	4,306	12,339	12,384	15,130	1,007	1,829	1,839
Mississippi	1,809	4,005	2,870	3,416	899	575	2,754
Missouri	2,435	5,975	4,149	6,043	906	1,276	333
Montana	3,599	9,500	3,507	7,543	832	1,564	1,118
Nebraska	3,103	8,421	7,586	8,710	926	1,560	2,397
Nevada	3,635	7,035	7,971	10,018	1,343	2,753	4,447
New Hampshire	4,779	12,040	14,507	11,883	986	1,501	0
New Jersey	4,019	11,592	6,471	10,776	950	2,281	0
New Mexico	2,259	6,622	6,847	6,301	1,153	1,682	0
New York	5,975	18,288	27,316	15,396	1,547	2,338	1,525
North Carolina	2,654	5,368	8,314	7,359	1,121	1,679	0
North Dakota	4,430	9,275	6,169	13,891	1,238	1,765	1,095
Ohio	2,987	10,090	3,815	8,474	1,098	1,564	340
Oklahoma	2,788	5,156	3,095	6,976	1,521	1,747	1,022
Oregon	2,532	6,906	16,468	8,237	905	1,298	0
Pennsylvania	3,019	10,038	3,435	6,477	912	1,451	1,295
Rhode Island	3,628	7,128	5,864	8,458	825	1,480	3,572
South Carolina	2,670	4,549	3,235	6,112	1,097	2,039	2,419
South Dakota	3,597	8,755	3,517	9,006	1,109	1,530	0
Tennessee	2,210	4,723	2,831	4,121	964	1,655	2,818

TABLE 18-23.—AVERAGE EXPENDITURE PER RECIPIENT BY BASIS OF ELIGIBILITY BY STATE: FISCAL YEAR 1992—Continued

State	Total	Aged	Blind	Disabled	AFDC Children	AFDC Adults	Other title XIX
Texas	2,177	5,284	4,193	6,481	887	1,685	0
Utah	2,662	7,318	7,532	9,694	985	2,206	4,962
Vermont	2,863	7,013	4,580	8,792	653	1,428	2,420
Virginia	2,934	6,204	4,869	6,841	1,116	1,936	0
Washington	2,368	8,301	4,784	5,214	791	1,825	689
West Virginia	2,580	6,312	4,433	5,618	844	1,880	11,274
Wisconsin	3,811	9,922	7,143	7,915	768	1,301	1,533
Wyoming	2,685	10,894	2,418	8,357	1,093	1,875	1,512
Puerto Rico	178	178	177	178	178	0	0
Virgin Islands	372	611	86	1,161	234	388	314

Source: HCFA, BDMS, Office Program Systems, Data from Division of Medicaid Statistics, December 22, 1993.

TABLE 18-24.—OPTIONAL MEDICAID SERVICES AND NUMBER OF STATES¹ OFFERING EACH SERVICE AS OF OCTOBER, 1993

Service	States offering service to categorically needy only	States offering service to both categorically and medically needy	Total
Podiatrists' services	14	33	47
Optometrists' services	16	35	51
Chiropractors' services	7	20	27
Psychologists' services	8	23	31
Medical social workers' services	2	5	7
Nurse Anesthetists' services	11	16	27
Private duty nursing	7	20	27
Clinic services	17	37	54
Dental services	16	34	50
Physical therapy	15	30	45
Occupational therapy	12	25	37
Speech, hearing and language disorder	16	27	43
Prescribed drugs	17	39	56
Dentures	11	30	41
Prosthetic devices	18	37	55
Eyeglasses	16	33	49
Diagnostic services	9	24	33
Screening services	8	23	31
Preventive services	7	23	30
Rehabilitative services	14	37	51
Services for age 65 or older in mental institution:			
A. Inpatient hospital services	16	24	40
B. SNF services	13	20	33
C. ICF/MR services	22	28	50
Inpatient psychiatric services for under age 21 ...	13	28	41
Christian Science nurses	3	2	5
Christian Science sanatoria	6	9	15
SNF for under age 21	23	29	52
Emergency hospital services	14	30	44
Personal care services	10	22	32
Transportation services	16	39	55
Case management services	12	33	45
Hospice services	10	25	35
Respiratory care services	5	11	16

¹ Includes the territories. Thus the maximum number is 53.

Source: Health Care Financing Administration, Office of Prepaid Health Care, Medicaid Bureau, Office of Intergovernmental Affairs.

APPENDIX A. DATA ON THE ELDERLY

This appendix presents historical and current data on the demographic and economic characteristics of the elderly, including information on population, life expectancy, labor force participation, marital status, living arrangements, poverty rates, and income. Data sources are noted at the bottom of each table.

The following definitions may be useful for reading the tables:

(1) "Aged" and "elderly" each refer to any person 65 years old or older.

(2) "OASDI" and "Social Security" are used interchangeably.

(3) "Supplemental security income" is, at times, abbreviated "SSI."

(4) The concepts "unrelated individual" and "unit" are used many times throughout this appendix. "Unrelated individual" refers to any individual living alone. "Unit" refers to an individual living alone, a couple living alone or a family.

TABLE A-1.—ELDERLY AS A PERCENT OF TOTAL POPULATION AND DISTRIBUTION OF ELDERLY BY AGE AND SEX, 1940 TO 2025

	1940	1950	1960	1970	1980	1990	2000 ¹	2025 ¹
Population 65 years and older (in thousands)	9,556	12,807	17,268	20,892	26,125	31,995	35,170	60,599
Population age 65 and older as a percent of total population	6.8	8.0	9.1	9.7	11.1	12.3	12.4	18.2
Population age 75 and older as a percent of total population	2.0	2.5	3.1	3.7	4.4	5.2	5.9	7.5
Population age 85 and older as a percent of total population	0.3	0.4	0.5	0.7	1.0	1.3	1.5	1.9
Certain age and sex groupings as a percent of the population 65 years and older:								
Total 65 years and older	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Men 65 and older	48.4	46.8	44.5	41.6	40.3	40.8	41.1	43.9
Men 65 to 74	34.8	32.6	30.2	26.9	26.3	25.9	23.9	27.8
Men 75 to 84	11.9	12.2	12.2	12.4	11.3	12.1	13.8	13.0
Men 85 and older	1.7	2.0	2.2	2.4	2.8	2.9	3.5	3.2
Women 65 and older	51.6	53.2	55.5	58.4	59.7	59.2	58.9	56.1
Women 65 to 74	35.8	35.7	35.7	34.7	33.9	31.8	28.5	31.0
Women 75 to 84	13.4	14.7	16.3	19.2	19.3	19.8	21.4	17.8
Women 85 and older	2.3	2.8	3.5	4.6	6.5	7.5	9.0	7.3

¹ Projection.

Note: Population data include total U.S. plus the outlying areas covered under the Social Security program and an adjustment for population undercount.

Source: 1993 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, and unpublished estimates from the Office of the Actuary, Social Security Administration. Population figures are as of July 1 of the year.

TABLE A-2.—LIFE EXPECTANCY¹ FOR MEN AND WOMEN, 1900–2070

Year	Life expectancy at birth		Life expectancy at age 65	
	Male	Female	Male	Female
Actual:				
1900	46.4	49.0	11.4	11.7
1910	50.1	53.6	11.4	12.1
1920	54.5	56.3	11.8	12.3
1930	58.0	61.3	11.8	12.9
1940	61.4	65.7	11.9	13.4
1950	65.6	71.1	12.8	15.1
1960	66.7	73.2	12.9	15.9
1970	67.1	74.9	13.1	17.1
1980	69.9	77.5	14.0	18.4
1990 ²	71.1	78.8	14.9	18.9
Projected³:				
2000	72.6	79.7	15.4	19.4
2010	74.0	80.5	15.8	19.7
2020	74.7	81.2	16.3	20.2
2030	75.3	81.8	16.7	20.6
2040	75.9	82.4	17.1	21.1
2050	76.5	82.9	17.5	21.5
2060	77.0	83.5	17.9	22.0
2070	77.5	84.0	18.3	22.4

¹The life expectancy for any year is the average number of years of life remaining for a person if that person were to experience the death rates by age observed in, or assumed for, the selected years.

²Estimated.

³Based on the intermediate mortality assumptions of the 1993 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds.

Source: Office of the Actuary, Social Security Administration.

TABLE A-3.—LABOR FORCE PARTICIPATION RATES¹, 1950-93

Sex	1950	1955	1960	1965	1970	1975	1980	1985	1990	1993
Men:										
55 to 64	86.9	87.9	86.8	84.6	83.0	75.8	72.3	67.9	67.7	66.5
55 to 59	(2)	92.5	91.6	90.2	89.5	84.4	81.9	79.6	79.8	78.2
60 to 64	(2)	82.5	81.1	78.0	75.0	65.7	61.0	55.6	55.5	54.1
60 to 61	(2)	(2)	(2)	84.8	82.6	75.2	71.8	68.9	68.8	66.1
62 to 64	(2)	(2)	(2)	73.2	69.4	58.8	52.8	46.1	46.4	46.1
65 and over	45.8	39.6	33.1	27.9	26.8	21.7	19.1	15.8	16.4	15.6
Women:										
55 to 64	27.0	32.5	37.2	41.4	43.0	41.0	41.5	42.0	45.3	47.3
55 to 59	(2)	35.6	42.2	47.1	50.4	47.9	48.6	50.3	55.3	57.1
60 to 64	(2)	29.0	31.4	34.0	36.1	33.3	33.3	33.4	35.5	37.1
60 to 61	(2)	(2)	(2)	40.4	41.4	39.5	39.8	40.3	42.9	45.2
62 to 64	(2)	(2)	(2)	29.5	32.3	29.0	28.6	28.7	30.7	31.8
65 and over	9.7	10.6	10.8	10.0	9.7	8.3	8.1	7.3	8.7	8.2

¹ Civilian labor force as percent of civilian noninstitutional population aged 16 or older.² Data not available.

Source: Bureau of Labor Statistics.

TABLE A-4.—MARITAL STATUS OF AGED INDIVIDUALS¹, 1960-92

	1960			1970 ²			1980 ³			1990			1992		
	65 to 74	75 and over		65 to 74	75 and over		65 to 74	75 and over		65 to 74	75 and over		65 to 74	75 and over	
Men:															
Number (in thousands)	4,778	2,280		5,333	3,031		6,459	3,234		8,013	4,320		8,266	4,533	
Percent	100.0	100.0		100.0	100.0		100.0	100.0		100.0	100.0		100.0	100.0	
Married															
Number (in thousands)	78.9	59.1		77.6	79.7		81.6	69.4		80.2	69.9		79.1	70.2	
Percent	12.7	31.6		11.0	30.4		8.5	24.0		9.2	23.7		10.2	23.7	
Widowed															
Number (in thousands)	1.7	1.5		2.9	1.5		4.4	2.2		6.0	3.1		6.1	2.6	
Percent	6.7	7.8		8.5	6.6		5.4	4.4		4.7	3.4		4.6	3.5	
Divorced															
Number (in thousands)															
Percent															
Never married															
Number (in thousands)	5,529	3,054		6,741	4,608		8,549	5,411		9,966	7,267		10,174	7,616	
Percent	100.0	100.0		100.0	100.0		100.0	100.0		100.0	100.0		100.0	100.0	
Married															
Number (in thousands)	45.6	21.8		45.4	20.8		50.1	23.3		53.2	25.4		53.0	25.6	
Percent	44.4	68.3		43.7	70.5		40.3	68.0		36.1	65.6		35.9	65.0	
Widowed															
Number (in thousands)	1.7	1.2		3.0	1.3		4.0	2.3		6.2	3.6		6.7	4.0	
Percent	8.4	8.6		7.9	7.4		5.6	6.4		4.6	5.4		4.4	5.4	
Divorced															
Number (in thousands)															
Percent															
Never married⁴															
Number (in thousands)															
Percent															

¹ Civilian noninstitutional population only.² Estimates based on weights derived from the 1960 decennial census.³ Estimates based on weights derived from the 1970 decennial census.⁴ Never married was reported as "single" for 1960.

Note: Details may not add to totals due to rounding.

Source: U.S. Bureau of the Census, Current Population Reports, series P-20, Nos. 135, 212, 365, 423, 445, 450, and 461.

TABLE A-5.—LIVING ARRANGEMENTS OF THE ELDERLY, 1970-92

[Civilian noninstitutionalized population, number in thousands]

Living arrangement	Total 65 and over		Widowed men		Widowed women	
	Number	Percent	Number	Percent	Number	Percent
Total:						
1970 ²	19,061	100.0	1,333	100.0	5,946	100.0
1980 ³	24,194	100.0	1,342	100.0	7,295	100.0
1990	29,566	100.0	1,755	100.0	8,367	100.0
1992	30,590	100.0	1,917	100.0	8,601	100.0
In families:						
1970 ²	13,347	70.0	499	37.4	2,386	40.1
1980 ³	16,355	67.6	385	28.7	2,194	30.1
1990	19,737	66.8	525	29.9	2,202	26.3
1992	20,351	66.5	53.6	28.0	2,305	26.8
Living alone:						
1970 ²	5,071	26.6	708	53.1	3,309	55.7
1980 ³	7,328	30.3	893	66.5	4,916	67.4
1990	9,176	31.0	1,117	63.6	5,946	71.1
1992	9,523	31.1	1,241	64.7	6,070	70.6
Other:						
1970 ²	645	3.4	124	9.3	251	4.2
1980 ³	511	2.1	65	4.8	186	2.5
1990	653	2.2	113	6.4	220	2.6
1992	716	2.3	142	7.4	227	2.6

¹ Excludes persons in institutions (nursing homes, etc.). The number of such persons age 65 years and over was estimated to be 0.8 million in 1970, and 1.6 million in 1989.

² Estimates based on weights derived from the 1970 decennial census.

³ Estimates based on weights derived from the 1980 decennial census.

Source: Bureau of the Census, Current Population Reports, P-20, Nos. 445, 450, 461 and unpublished data.

TABLE A-6.—POVERTY STATUS OF ALL PERSONS, AND THE ELDERLY BY SEX, RACE/ETHNICITY AND LIVING ARRANGEMENT, 1959-92
[Percent below the poverty level]

	1959	1966	1970	1973 ¹	1980	1990	1992
All persons	22.4	14.7	12.6	11.1	13.0	13.5	14.5
Persons 65 years old and over	35.2	28.5	24.5	16.3	15.7	12.2	12.9
Both sexes:							
Living arrangement:							
Living in families	NA	NA	14.7	9.4	8.5	5.8	7.1
Unrelated individuals	NA	NA	47.1	32.0	30.6	24.7	24.9
Race/ethnicity:							
Black	NA	NA	48.0	37.1	38.1	21.9	22.0
Hispanic ²	NA	NA	NA	24.9	30.8	14.6	14.2
White	NA	NA	22.5	14.4	13.6	4.3	5.7
Men	NA	NA	19.0	12.4	10.9	7.6	8.9
Living arrangement:							
Living in families	NA	NA	14.9	9.4	8.2	5.4	6.7
Unrelated individuals	NA	NA	38.9	27.1	24.4	17.3	18.6
Race/ethnicity:							
Black	NA	NA	41.3	32.4	31.4	27.8	26.9
Hispanic ²	NA	NA	NA	22.0	27.0	18.6	17.4
White	NA	NA	17.0	10.4	9.0	5.6	7.1
Women	NA	NA	28.5	19.0	19.0	15.4	15.7
Living arrangement:							
Living in families	NA	NA	14.5	9.3	8.8	6.3	7.5
Unrelated individuals	NA	NA	49.7	33.5	32.3	26.9	26.8
Race/ethnicity:							
Black	NA	NA	53.2	40.5	42.6	37.9	37.7
Hispanic ²	NA	NA	NA	24.7	34.3	25.3	25.3
White	NA	NA	26.5	17.2	16.8	13.2	13.6

¹ First year in which Hispanic data are available. ² Hispanics may be of any race. NA—Not available.
Source: U.S. Bureau of the Census, Current Population Reports series P-60.

TABLE A-7.—POVERTY RATES OF THE ELDERLY BY AGE, SEX, AND MARITAL STATUS:
1992

	65 and over	65 to 74	75 to 84	85 and over
Male total	8.9	8.1	9.7	13.2
Married	6.6	6.0	7.5	10.5
Widowed	15.0	13.7	15.7	16.7
Divorced/separated/never married	17.6	18.1	16.5	NA
Female total	15.7	12.7	18.9	22.7
Married	6.4	5.6	8.0	NA
Widowed	21.5	18.9	23.2	23.8
Divorced/separated/never married	26.0	25.6	27.0	NA
Total	12.9	10.7	15.3	19.8

NA—Not available due to unreliability of estimate. Percentage base represents fewer than 250,000 persons.

Source: March 1993 Current Population Survey (CPS). Table prepared by CRS.

TABLE A-8.—TOTAL MONEY INCOME OF ELDERLY UNITS, 1992

Amount of income	All units			Married couples			Nonmarried persons		
	Age 65 and over	Age 65-69	Age 85 and over	Age 65 and over	Age 65-69	Age 85 and over	Age 65 and over	Age 65-69	Age 85 and over
Number (in thousands)	23,579	6,746	2,409	9,595	3,395	427	13,983	3,351	1,982
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
0-\$4,999	8.2	7.0	13.6	2.4	2.4	4.3	12.2	11.5	15.9
\$5,000-\$9,999	26.8	19.3	41.0	7.5	6.4	10.3	40.2	32.4	47.5
\$10,000-\$14,999	17.9	15.9	19.1	14.2	12.3	20.7	20.6	19.4	18.9
\$15,000-\$19,999	12.4	12.2	9.9	15.3	11.6	21.2	10.4	12.7	7.5
\$20,000-\$29,999	15.8	18.8	8.0	24.8	24.3	17.9	9.5	13.3	5.9
\$30,000-\$39,999	8.0	10.6	3.9	14.9	16.9	10.4	3.4	4.2	2.4
\$40,000-\$49,999	4.1	5.6	2.2	7.5	8.4	7.5	1.7	2.7	1.1
\$50,000-\$74,999	3.7	5.6	1.0	7.2	9.2	3.0	1.4	2.1	0.4
\$75,000-\$99,999	1.1	2.1	0.4	2.8	3.5	1.7	0.4	0.7	0.2
\$100,000-\$149,999	0.3	2.1	0.3	2.2	3.4	1.7	0.3	0.7	0.0
\$150,000-\$199,999	0.3	0.7	0.2	0.7	1.3	1.3	0.1	0.1	0.0
\$200,000 or more	0.2	0.3	0.2	0.4	0.5	0.3	0.1	0.1	0.2
Median	\$13,959	\$18,087	\$9,299	\$23,817	\$26,873	\$18,347	\$9,554	\$11,302	\$8,108

Source: 1993 Current Population Survey, tabulated by the Office of Research and Statistics, Social Security Administration.

TABLE A-9.—AMOUNT OF INCOME FROM SOURCES OTHER THAN SOCIAL SECURITY,
AMONG SOCIAL SECURITY BENEFICIARIES AGE 65 AND OVER, 1992

Unit income other than Social Security	All units	Married couples	Nonmarried persons
Number (in thousands)	21,719	8,958	12,762
Total percent	100.0	100.0	100.0
None	14.2	6.4	19.7
Loss or \$1-\$1,999	20.7	12.0	17.8
\$2,000-\$3,999	10.8	7.7	12.9
\$4,000-\$5,999	8.1	6.8	9.0
\$6,000-\$7,999	7.1	7.9	6.5
\$8,000-\$9,999	5.7	6.4	5.3
\$10,000-\$14,999	9.9	13.3	1.8
\$15,000-\$19,999	6.2	9.4	3.9
\$20,000-\$29,999	7.5	12.5	4.0
\$30,000-\$39,999	3.9	6.9	1.8
\$40,000-\$74,999	3.8	6.9	1.7
\$75,000-\$99,999	0.9	1.7	0.3
\$100,000-\$199,999	0.9	2.0	0.1
\$200,000 or more	0.1	0.2	0.1
Median income other than Social Security	\$4,918	\$10,937	\$2,357
Median Social Security income	\$8,044	\$11,656	\$6,748

Source: 1993 Current Population Survey, tabulated by the Office of Research and Statistics, Social Security Administration.

TABLE A-10.—INCOME SOURCES OF ELDERLY UNITS¹ AND RELATIVE IMPORTANCE OF SOURCES, 1992

	Percent of units with income from each source			Percent of aggregate unit income from each source		
	Total	Poor ²	Nonpoor	Total	Poor ²	Nonpoor
Number of units (in thousands)	23,187	3,514	19,673	NA	NA	NA
Number of aged individuals (in thousands)	30,870	3,983	26,887	NA	NA	NA
Percent of units	100.0	15.2	84.8	NA	NA	NA
Earnings ³	32.3	9.3	36.4	30.0	5.0	30.9
OASDI, railroad retirement	93.6	89.8	94.2	32.6	67.7	31.3
Pensions	45.6	8.6	52.2	16.0	2.6	16.4
Unemployment compensation, workers compensation, veterans payments	8.8	4.8	9.5	1.5	1.6	1.5
AFDC, SSI, general assistance	8.7	25.3	5.7	1.0	10.0	0.7
Child support, alimony	5.3	2.7	5.7	0.9	0.6	0.9
Interest, dividends ³	70.1	33.7	76.6	17.5	3.5	18.0
Food stamps ⁴	5.7	23.6	2.5	0.2	3.1	0.1
Housing assistance ⁴	5.9	16.9	3.9	0.4	5.8	0.2

¹ Families and unrelated individuals with any member age 65 or older.

² Based on census ("Orshansky") poverty levels.

³ Negative income (i.e., losses) set to zero.

⁴ The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

NA—Not applicable.

Note: Details may not sum to totals due to rounding.

Source: March 1993 Current Population Survey (CPS). Table prepared by CRS.

TABLE A-11.—INCOME SOURCES OF ELDERLY MARRIED COUPLES AND RELATIVE IMPORTANCE OF SOURCES, 1992

	Percent of couples with income from each source			Percent of aggregate total income from each source		
	Total	Poor ²	Nonpoor	Total	Poor ²	Nonpoor
Number of married couples (in thousands)	6,076	347	5,729	NA	NA	NA
Percent of married couples	100.0	5.7	94.3	NA	NA	NA
Earnings ³	20.8	5.5	21.8	12.8	2.5	12.9
OASDI, railroad retirement	97.2	86.5	97.8	40.7	73.1	40.3
Pensions	60.9	14.6	63.7	22.0	4.8	22.2
Veterans, UC, and other compensation	8.4	3.7	8.7	1.3	2.0	1.3
AFDC, SSI, general assistance	2.4	14.4	1.7	0.3	7.9	0.2
Child support, alimony	3.0	0.4	3.2	0.5	0.0	0.5
Interest, dividends ³	82.4	45.4	84.6	22.5	5.2	22.7
Food stamps ⁴	1.6	17.8	0.6	0.0	2.9	0.0
Housing assistance ⁴	1.3	4.4	1.1	0.1	1.6	0.0

¹ Both members age 65 or over.

² Based on Orshansky poverty levels.

³ Negative incomes (i.e., losses) set to zero.

⁴ The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

NA—Not applicable.

Source: March 1993 Current Population Survey (CPS). Table prepared by CRS.

TABLE A-12. INCOME SOURCES OF ELDERLY UNRELATED INDIVIDUALS¹ AND RELATIVE IMPORTANCE OF SOURCES, 1992

	Percent of units with income from each source			Percent of aggregate total income from each source		
	Total	Poor ²	Nonpoor	Total	Poor ²	Nonpoor
Number of individuals (in thousands)	10,041	2,498	7,543	NA	NA	NA
Percent of individuals	100.0	24.9	75.1	NA	NA	NA
Earnings ³	12.4	2.9	15.5	10.0	0.7	11.0
OASDI, Railroad retirement	94.9	92.5	95.7	45.2	74.6	42.2
Pensions	37.8	7.3	47.9	17.4	2.1	18.9
Veterans, UC, and other compensation	5.0	3.8	5.5	1.5	0.9	1.6
AFDC, SSI, general assistance	8.3	23.7	3.2	1.2	8.2	0.4
Child support, alimony	3.5	1.6	4.2	0.8	0.4	0.9
Interest, dividends ³	63.9	33.9	73.8	22.3	3.3	24.3
Food stamps ⁴	7.0	22.2	1.9	0.2	2.0	0.0
Housing assistance ⁴	11.2	20.9	8.0	1.4	7.9	0.7

¹ Age 65 and over living alone.² Based on ("Orshansky") poverty levels.³ Negative incomes (i.e., losses) set to zero.⁴ The cash values of food stamps and housing assistance were estimated using their market values. Their cash values are excluded from total income for purposes of determining poverty status. Cash values of food stamps and housing assistance are included in total income for calculating the percentage share of total income.

NA—Not applicable.

Source: March 1993 Current Population Survey (CPS). Table prepared by CRS.

TABLE A-13.—RECEIPT OF SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME AND FOOD STAMPS, AMONG POOR AND NEAR-POOR ELDERLY UNITS,¹ 1992

Type of benefit received	Units with income below 100 percent of poverty threshold		Units with income of 100 to 149.9 percent of poverty threshold	
	Number (in thousands)	Percent	Number (in thousands)	Percent
Total	3,377	100.0	3,578	100.0
Social Security ²	3,057	90.5	3,483	97.3
SSI	761	22.5	393	11.0
Food stamps	779	23.1	237	6.6
Social Security only ³	2,131	63.1	2,993	83.7
SSI only ³	51	1.5	25	0.7
Food stamps only ³	19	0.6	0	0.0
Social Security and food stamps ⁴	308	9.1	133	3.7
Social Security and SSI ⁴	258	7.6	263	7.4
SSI and food stamps ⁴	92	2.7	11	0.3
All three income sources	360	10.7	93	2.6
No Social Security, SSI, or food stamps	158	4.7	59	1.6

¹Includes couples with an elderly head and unrelated individuals.

²Includes railroad retirement.

³This row, which is labeled "social security only", means the family receives only Social Security and does not receive SSI or food stamps. The family could be receiving other types of income. The same is true of the following 2 rows.

⁴Family receives only the two types of income specified but not the third. The family could be receiving other sources of income than the three mentioned.

Source: March 1993 Current Population Survey (CPS). Table prepared by CRS.

APPENDIX B. HEALTH STATUS, INSURANCE, AND EXPENDITURES OF THE ELDERLY, AND BACKGROUND DATA ON LONG-TERM CARE

Although the health status of the elderly appears to have been improving in recent decades, many elderly persons have conditions that require medical and long-term health care, sometimes in substantial amounts. Nearly all elderly persons have some insurance that protects them, at least partially, from the expenses arising from health care use. Many are well insured for their acute care needs—that is, for hospital and physician services. Others face greater risk of high out-of-pocket expenditures. This appendix reports on the health status, health insurance, and health care expenditures of the elderly.

HEALTH STATUS

By various measures, the health status of the elderly population has been improving over the years. For example, life expectancy at age 65 has increased from 13.9 years in 1950 to 17.2 years in 1989 (see table B-1). The improvements in life expectancy—or, alternatively, the declines in mortality rates—have been greater for females than for males. Morbidity indicators—such as the incidence of high blood pressure—also improved among those aged 65 to 74 years between the early 1960's and the late 1970's (see table B-2).

TABLE B-1.—LIFE EXPECTANCY AT BIRTH AND AT 65 YEARS OF AGE, BY SEX, BY RACE, UNITED STATES, SELECTED YEARS 1900-90

[Remaining life expectancy in years]

Year	At birth			At 65 years			At birth	
	Both sexes	Male	Female	Both sexes	Male	Female	White	Black
1900 ^{1 2}	47.3	46.3	48.3	11.9	11.5	12.2	47.6	³ 33.0
1950 ²	68.2	65.6	71.1	13.9	12.8	15.0	69.1	60.7
1960 ²	69.7	66.6	73.1	14.3	12.8	15.8	70.6	63.2
1970	70.9	67.1	74.8	15.2	13.1	17.0	71.7	64.1
1980	73.7	70.0	77.4	16.4	14.1	18.3	74.4	68.1
1984	74.7	71.2	78.2	16.8	14.6	18.6	75.3	69.7
1985	74.7	71.2	78.2	16.7	14.6	18.6	75.3	69.5
1986	74.8	71.3	78.3	16.8	14.7	18.6	75.4	69.4
1987	75.0	71.5	78.4	16.9	14.8	18.7	75.6	69.4
1988	74.9	71.5	78.3	16.9	14.9	18.6	75.6	69.2
1989	75.3	71.8	78.6	17.2	15.2	18.8	76.0	69.2
Provisional data:								
1988 ²	74.9	71.4	78.3	16.9	14.8	18.6	75.5	69.5
1989 ²	75.2	71.8	78.5	17.2	15.2	18.8	75.9	69.7
1990 ²	75.4	72.0	78.8	17.3	15.3	19.0	76.0	70.3

¹ Death registration area only; includes 10 States and the District of Columbia.² Includes deaths of nonresidents of the United States.³ Figure is for the all other population.

Source: National Center for Health Statistics, Health, United States, 1989, Hyattsville, Maryland: Public Health Service, 1990.

TABLE B-2.—SELECTED HEALTH STATUS INDICATORS FOR PERSONS 65-74 YEARS OF AGE, BY SEX, 1960-62, 1971-74, AND 1976-80
[Percent of population]

Health status indicator	Both sexes			Male			Female		
	1960-62	1971-74	1976-80	1960-62	1971-74	1976-80	1960-62	1971-74	1976-80
Borderline or definite elevated blood pressure ¹	73.8	70.3	63.1	65.9	65.4	62.0	80.3	74.1	63.9
Definite elevated blood pressure ²	48.7	40.9	34.5	40.5	36.4	33.3	55.4	44.4	35.5
High-risk serum cholesterol levels ³	37.3	31.3	27.2	20.8	19.9	18.1	50.8	40.0	34.3
Overweight ⁴	34.6	31.5	32.7	23.8	23.0	25.2	43.3	38.0	38.5

¹ Borderline or definite elevated blood pressure is defined as either systolic pressure of at least 140 mmHg or diastolic pressure of at least 90 mmHg or both based on a single measurement.

² Definite elevated blood pressure is defined as either systolic pressure of at least 160 mmHg or diastolic pressure of at least 95 mmHg or both based on a single measurement.

³ High-risk serum cholesterol levels are defined by age-specific cut points of the cholesterol distribution. For 40 years of age and over, high risk is greater than 260 milligrams/deciliter. Risk levels defined by NIH Consensus Development conference statement on lowering blood cholesterol, December 10, 1984.

⁴ Overweight is defined for men as body mass index greater than or equal to 27.8 kilograms/meter², and for women as body mass index greater than or equal to 27.3 kilograms/meter². These cut points were used because they represent the sex-specific 85th percentiles for persons 20-29 years of age in the 1976-80 National Health and Nutrition Examination Survey.

Source: National Center for Health Statistics, Health, United States, 1985, DHHS Pub. No. (PHS) 86-1232, pp. 76-79. Data are based on physical examinations of a sample of the civilian, noninstitutionalized population.

Despite the trend toward improved health status of the elderly, their needs for medical and long-term care services remain substantial. First, greater life expectancy postpones the probable need for terminal illness care. (About two-thirds of the deaths in the United States are of the elderly. A recent study found that the 6 percent of Medicare beneficiaries who died in 1978 accounted for 28 percent of Medicare expenditures.¹) Second, many of the elderly have one or more chronic conditions, many of which give rise to the need for continuing health care. Table 3 shows the incidence of several common chronic conditions among the elderly. Nearly half report having arthritis, about 40 percent report high blood pressure, and almost 30 percent report heart disease. The incidence of many chronic conditions is directly related to age and inversely related to family income.

Self-assessed health is a common method used to measure health status, with responses ranging from "excellent" to "poor." Nearly 71 percent of elderly people living in the community describe their health as excellent, very good, or good, compared with others their age; only 29 percent report that their health is fair or good (see table B-4).

Income is directly related to one's perception of his or her health. About 26 percent of older people with incomes over \$35,000 described their health as excellent compared to others their age, while only 10 percent of those with low incomes (less than \$10,000) reported excellent health.

TABLE B-3.—SELECTED CHRONIC CONDITIONS PER 1,000 ELDERLY PERSONS, BY AGE AND FAMILY INCOME, 1988

Chronic condition	All elderly	Age		Family income			
		65-74	75 and over	Less than \$10,000	\$10,000 to \$19,999	\$20,000 to \$34,999	\$35,000 and over
Arthritis	486	445	550	608	452	471	397
Cataracts	168	118	246	183	174	131	150
Hearing impairment .	315	274	381	308	364	259	314
Deformity or orthopedic impairment	161	151	177	182	179	136	140
Hernia of abdominal cavity	58	54	64	72	67	46	51
Diabetes	92	95	88	98	101	76	71
Heart disease	296	272	334	346	324	269	257
High blood pressure .	373	373	374	472	396	345	321
Emphysema	38	36	41	52	48	34	(1)

¹ Sample size is too small for reliable estimate.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, Vital and Health Statistics: Current estimates from the National Health Interview Survey, 1988, Series 10, No. 173, October 1989.

¹ J. Lubitz and R. Prihoda, "The Use and Costs of Medicare Services in the Last Two Years of Life," Health Care Financing Review, Volume 5, 1984, pp. 117-131.

TABLE B-4.—SELF-ASSESSED HEALTH STATUS OF THE ELDERLY, BY FAMILY INCOME, 1989

[In percent]

Characteristic	All persons ¹ (thousands)	All health status ³	Self-assessed health status ²				
			Excellent	Very good	Good	Fair	Poor
All persons 65 ⁴	29,219	100.0	16.4	23.1	31.9	19.3	9.2
Sex:							
Men	12,143	100.0	16.9	23.2	30.8	18.4	10.7
Women	17,076	100.0	16.1	23.0	32.8	20.0	8.1
Family income:							
Under \$10,000	5,612	100.0	10.3	19.4	29.7	25.0	15.6
\$10,000 to \$19,999	8,002	100.0	14.8	21.7	33.9	21.1	8.5
\$20,000 to \$34,999	5,242	100.0	20.2	25.7	32.5	15.7	5.9
\$35,000 and over	3,484	100.0	26.0	26.8	30.3	11.7	5.1

¹Includes unknown health status.²Excludes unknown health status.³The categories related to this concept result from asking the respondent, "Would you say—health is excellent, very good, good, fair, or poor?" As such, it is based on the respondent's opinion and not directly on any clinical evidence.⁴Includes unknown family income.

Note.—Percentages may not add to 100 percent due to rounding.

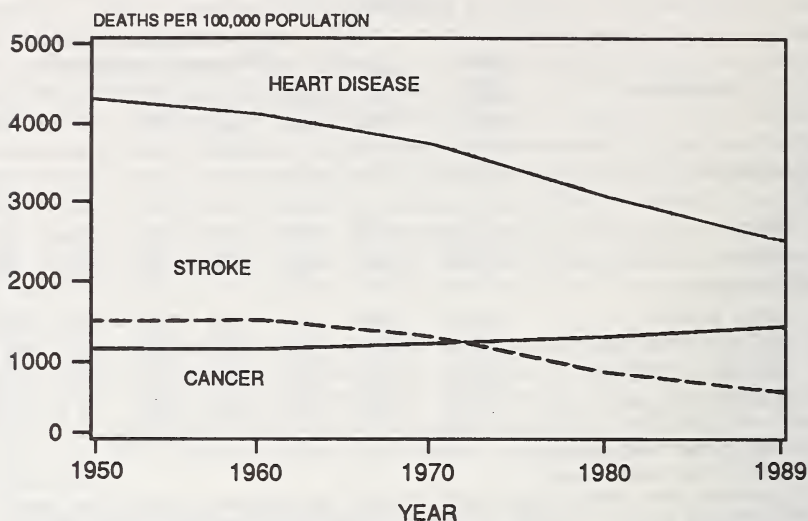
Source: National Center for Health Statistics. "Current Estimates from the National Health Interview Survey, 1989." Vital and Health Statistics Series 10, No. 176 (October 1990). Data are based on household interviews of the civilian, noninstitutionalized population.

CAUSES OF DEATH FOR THE ELDERLY²

In the United States, about 7 out of every 10 elderly persons die from heart disease, cancer, or stroke. Heart disease was the major cause of death in 1950, and remains so today even though there have been rapid declines in death rates from heart disease since 1968, especially among females. Death rates from cancer continue to rise in comparison to heart disease, especially deaths caused by lung cancer (chart B-1). In 1988, however, heart disease accounted for 40 percent of all deaths among persons 65+, while cancer accounted for 21 percent of all deaths in this age group.³ Even if cancer were eliminated as a cause of death, the average life span would be extended by less than 2 years because of the prevalence of heart disease. Eliminating deaths due to heart disease, on the other hand, would add an average of 5 years to life expectancy at age 65, and would lead to a sharp increase in the proportion of older persons in the total population.⁴

²This entire section is from Aging America: Trends and Projections, 1987-88 edition.³National Center for Health Statistics. "Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1985." Monthly Vital Statistics Report Vol. 34, No. 13 (September 1986).⁴National Center for Health Statistics. "United States Life Tables Eliminating Certain Causes of Death." U.S. Decennial Life Tables for 1979-81 Vol. 1, No. 2 (forthcoming).

CHART B-1. DEATH RATES FOR LEADING CAUSES OF DEATH FOR PEOPLE AGE 75-84: 1950-89



SOURCES: National Center for Health Statistics, *Health, United States, 1989*. DHHS Pub. No. (PHS)90-1232, Washington: Department of Health and Human Services (March 1990).

National Center for Health Statistics, "Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1989." *Monthly Vital Statistics Report* Vol. 38, No. 13 (August 30, 1990).

National Center for Health Statistics, "Advance Report of Final Mortality Statistics, 1988." *Monthly Vital Statistics Report* Vol. 39, No. 7, Supplement (November 28, 1990).

The third leading cause of death among the elderly—stroke (cerebrovascular disease)—has been decreasing over the past 30 years. Reasons for this dramatic decline are not fully understood. Part of the decline may be attributable to better control of hypertension. Better diagnosis and improved management and rehabilitation of stroke victims may also be related factors.⁵ In 1988, cerebrovascular disease accounted for only 8 percent of all deaths in the 65+ age group.

Table B-5 shows the 10 leading causes of death for three subgroups of the older population.

The factors which have led to reductions in mortality may or may not also lead to overall improvements in health status. If Americans continue to live only to about age 85, control of life-threatening disease could produce a healthier older population. But, if the life-span is increased dramatically in future years beyond age 85, the onset of illness may only be delayed, without an actual shortening of the period of illness.

⁵National Center for Health Statistics. *Health, United States, 1985*. DHHS Pub. No. (PHS) 86-1232, Washington: Department of Health and Human Services, December 1985.

TABLE B-5.—DEATH RATES FOR TEN LEADING CAUSES OF DEATH AMONG OLDER PEOPLE, BY AGE: 1988

[Rates per 100,000 population in age group]

Cause of death	65+	65-74	75-84	85+
All causes	5,105	2,730	6,321	15,594
Diseases of the heart	2,066	984	2,543	7,098
Malignant neoplasms	1,068	843	1,313	1,639
Cerebrovascular diseases	431	155	554	1,707
Chronic obstructive pulmonary diseases ...	226	152	313	394
Pneumonia and influenza	225	60	257	1,125
Diabetes	97	62	125	222
Accidents	89	50	107	267
Atherosclerosis	69	15	70	396
Nephritis, nephrotic syndrome, nephrosis .	61	26	78	217
Septicemia	56	24	71	199
All other causes	717	359	890	2,330

Source: National Center for Health Statistics. "Advanced Report of Final Mortality Statistics, 1988." Monthly Vital Statistics Report Vol. 39, No. 7, Supplement (November 28, 1990).

MEDICARE REIMBURSEMENT AND OUT-OF-POCKET LIABILITIES OF THE ELDERLY

Tables B-6 through B-8 illustrate for 6 selected years how Medicare reimbursement, acute health care costs, and out-of-pocket liabilities of Medicare enrollees have changed. The years chosen are 1975, 1980, 1985, 1990, 1995, and 2000 (projected values). Constant 1990 dollar values were obtained using the CPI-U.

The fastest-growing component of Medicare reimbursement is for benefits under the Supplementary Medical Insurance (SMI) program. For SMI, reimbursements increase at an annual rate of 13.3 percent, while the growth in total costs (including enrollees' share of costs) is 11.3 percent (see table B-6). As a result, the share of SMI costs reimbursed by Medicare increases significantly over the period—from about 64 percent in 1975 to about 74 percent by 1990. Through 1985, the growth in Medicare's share is due to the declining significance of the SMI deductible, so that more enrollees' costs were eligible for reimbursement.

In the Hospital Insurance (HI) program, by contrast, the rate of growth in reimbursement is slower than the growth in enrollee's copayment costs. Consequently, the share of HI costs reimbursed by Medicare has decreased from 93 percent in 1975 to 91 percent in 1990.

Overall, the share of costs reimbursed by Medicare has increased slightly. The percentage of costs paid by Medicare for services covered under Medicare was 82.2 percent in 1975 and 83.4 percent in 1990 (see table B-6). The other side of this—the share of costs paid directly by enrollees—is shown in the third panel of table B-7. Total direct costs plus Medicare reimbursement equals the total or 100 percent.

TABLE B-6.—REIMBURSEMENTS AND OUT-OF-POCKET COSTS UNDER MEDICARE, SELECTED CALENDAR YEARS

[Incurred costs per HI or SMI enrollee]

	1975	1980	1985	1990	1995	2000	Annual growth 1975- 2000 (per- cent)
In current dollars							
Hospital insurance:							
Reimbursement	\$458	\$906	\$1,539	\$1,959	\$3,027	\$4,385	9.5
Copayments	34	66	117	188	246	329	9.5
Total	492	972	1,656	2,146	3,273	4,714	9.5
Supplementary medical insurance:							
Reimbursement	184	402	763	1,298	1,951	3,309	12.2
Copayments	83	138	246	394	544	864	9.8
Balance-billing	22	56	87	68	42	67	4.6
Total	289	597	1,096	1,760	2,537	4,240	11.3
Total Medicare reimbursement	642	1,308	2,302	3,257	4,978	7,694	10.4
Total costs under Medicare	781	1,569	2,752	3,906	5,810	8,954	10.2

Hospital insurance:						
Reimbursement	1,065	1,439	1,870	1,959	2,589	3,221
Copayments	79	104	143	188	210	242
Total	1,144	1,543	2,012	2,146	2,800	3,463
Supplementary medical insurance:						
Reimbursement	428	639	927	1,298	1,669	2,431
Copayments	193	220	299	394	465	635
Balance-billing	51	89	106	68	36	49
Total	672	947	1,332	1,760	2,170	3,115
Total Medicare reimbursement						
Total costs under Medicare	1,493	2,077	2,797	3,257	4,258	5,752
Percent of costs paid by Medicare	1,816	2,490	3,344	3,906	4,970	6,578
	82.2	83.4	83.6	83.4	85.7	85.9
						0.2
						4.5
						4.6
						4.9
						-0.2
						6.3
						7.2
						4.5
						4.6

Note.—1995 values are projected. The CPI-U was used to obtain constant dollars.

Source: Congressional Budget Office (February 1993 baseline).

TABLE B-7.—ENROLLEE COSTS UNDER MEDICARE, SELECTED CALENDAR YEARS

[Incurred costs per HI or SMI enrollee]

	1975	1980	1985	1990	1995	2000	Annual growth 1975- 2000 (per- cent)
In current dollars							
HI copayments	\$34	\$66	\$117	\$188	\$246	\$329	9.5
SMI copayments	83	138	246	394	544	864	9.8
Balance-billing	22	56	87	68	42	67	4.6
Total direct costs	139	260	451	649	832	1,260	9.2
Premium costs	80	110	186	343	553	728	9.2
Total enrollee costs	219	371	637	993	1,385	1,988	9.2
Enrollee per capita income ¹							
	5,158	8,431	12,767	15,454	19,141	23,074	6.2
In constant 1990 dollars							
HI copayments	79	104	143	188	210	242	4.6
SMI copayments	193	220	299	394	465	635	4.9
Balance-billing	51	89	106	68	36	49	-0.2
Total direct costs	323	413	547	649	712	926	4.3
Premium costs	187	175	226	343	473	535	4.3

Total enrollee costs	510	588	773	993	1,185	1,461	4.3
Enrollee per capita income ¹	11,998	13,386	15,513	15,454	16,374	16,951	1.4
Percent of costs under Medicare paid by enrollees, by source of payment							
HI copayments	4.3	4.2	4.3	4.8	4.2	3.7	-0.7
SMI copayments	10.6	8.8	8.9	10.1	9.4	9.6	-0.4
Balance-billing	2.8	3.6	3.2	1.7	0.7	0.7	-5.2
Total direct costs	17.8	16.6	16.4	16.6	14.3	14.1	-0.9
Premium costs	10.3	7.0	6.8	8.8	9.5	8.1	-0.9
Total	28.1	23.6	23.1	25.4	23.8	22.2	-0.9
Enrollee-paid costs as a percent of enrollee per capita income ¹	4.3	4.4	5.0	6.4	7.2	8.6	2.9

¹ From Current Population Survey, adjusted for underreporting.

Note.—1995 values are projected. The CPI-U was used to obtain constant dollars.

Source: Congressional Budget Office (February 1994 baseline).

In constant dollars, HI copayments have increased the most rapidly between 1975 and 1995. However, between 1990 and 1995, premium costs are expected to rise the most rapidly due equally to copayments and premiums. In contrast, the cost to the enrollee from balance-billing has decreased significantly since 1985—a direct policy result of the participating physician program and the imposition of lower limits on balance billing. See table B-8 for deductible amounts and monthly premium amounts under Medicare.

Enrollees are spending an increasing share of their income for health care. In 1975, about 4.3 percent of enrollees' per capita income went to cover their share of acute health care costs under Medicare. By 2000, enrollees will have to pay an estimated 8.6 percent of their per capita income to cover their share of costs under Medicare.

Although direct household spending for health care by elderly households, that is households headed by a person 65 or older, as a share of household income has increased since the early 1970's, it has remained relatively stable in recent years. Chart B-2 illustrates direct household spending for health care as a percentage of household income before taxes for elderly and nonelderly households for years 1984 through 1992. In 1992, direct household spending for health care as a percentage of household income for elderly households was 11.9 percent, on average, up slightly from 10.6 percent in 1984. Over the same period, nonelderly households spent around 3.5 percent of their household income for health care.

TABLE B-8.—COPAYMENT AND PREMIUM VALUES UNDER MEDICARE, SELECTED CALENDAR YEARS

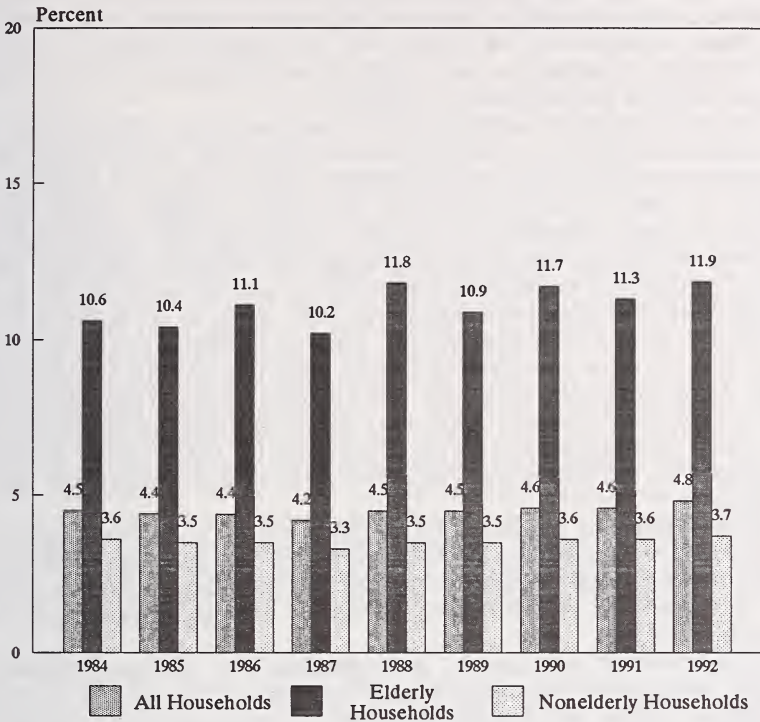
	1975	1980	1985	1990	1995	2000	Annual growth 1975-2000 (in percent)
In current dollars							
Hospital insurance:							
Hospital deductible	\$92	\$180	\$400	\$592	\$720	\$916	9.6
Supplementary medical insurance:							
Annual deductible	60	60	75	75	100	100	2.1
Monthly premium ¹	6.70	9.20	15.50	28.60	46.10	60.70	9.2
In constant 1990 dollars							
Hospital insurance:							
Hospital deductible	214	286	486	592	616	673	4.7
Supplementary medical insurance:							
Annual deductible	139	95	91	75	86	73	-2.5
Monthly premium ¹	15.57	14.61	18.83	28.60	39.43	44.59	4.3

¹The 1980 SMI monthly premium amount is the average of values for the first and second halves of the year.

Note:—Values after 1990 are projected. The CPI-U was used to get constant dollars.

Source: Congressional Budget Office (February 1994 baseline).

CHART B-2. DIRECT HOUSEHOLD SPENDING FOR HEALTH CARE AS A PERCENTAGE OF HOUSEHOLD INCOME BY TYPE OF HOUSEHOLD, 1984-92



SOURCE: Congressional Budget Office calculations based on data from the Consumer Expenditure Surveys (CES) of the Bureau of Labor Statistics, 1984-1992.

NOTES: Direct household spending for health care consists of the amount directly paid for health insurance premiums by a household, as well as out-of-pocket spending for health care services, including deductibles and copayments.

Elderly households are those in which the primary home owner or renter in the household is 65 or older. Such households may include individuals younger than 65. Nonelderly households are those in which the primary home owner or renter in the household is younger than 65. Such households may include individuals age 65 or older.

Although expenditures for health care by the institutionalized population are not collected by the CES, if a member residing in the household contributes to health-related expenses of an institutionalized person, then those expenditures are counted as direct household spending for health care.

Household income refers to income before taxes.

ANALYZING TRENDS IN MEDICARE SPENDING, 1967-98⁶

Between 1980 and 1985, total Medicare spending for hospital inpatient services grew at an annual rate of 14.6 percent. The estimated growth rate for 1985 to 1992 is 6.8 percent. The difference in these rates is due to changes in four separate trends: Medicare enrollment, admissions per enrollee, real expenditures per admission, and the general rate of inflation.

Reduced inflation contributes to the lower rate of growth in total Medicare inpatient spending. General inflation is estimated at 3.9 percent per year from 1985 to 1992, compared with 5.6 percent for 1980 to 1985. The growth rate for 1985 to 1992 would thus be about 1.7 percentage points higher at the previous rate of inflation.

Real Medicare inpatient spending per enrollee removes the effects of changes in Medicare enrollment and general inflation from total Medicare inpatient spending (see table B-9). Since both enrollment and prices are almost always increasing, the growth of real per enrollee spending is slower than the growth of total spending. Real inpatient spending per enrollee grew at an annual rate of 6.4 percent between 1980 and 1985, and the estimate for 1985 to 1992 is 0.1 percent. The difference in these rates is due to changes in admissions per enrollee and real expenditures per admission.

The number of Medicare enrollees grew at an annual rate of 1.7 percent between 1980 and 1985, and the estimate for 1985 to 1991 is about the same. Medicare enrollment thus makes no contribution to the observed difference in spending growth between the early and late 1980's.

The trend in admissions per enrollee did change, however. In 1984, Medicare's peer review organizations were set up to monitor inpatient cases for appropriateness of treatment and site of care. Simultaneously, admission rates among the Medicare population—which had been increasing through 1983—began to decline. Although admission rates inched up again after 1987, rates in 1989 for people age 65 or more (a proxy for the Medicare population) were still only 85 percent of rates in 1983. Perhaps Medicare's preadmission approval requirements for certain procedures, coupled with retrospective payment denials for care deemed inappropriate, encouraged physicians either to forgo some elective procedures for their Medicare patients or to move them to the outpatient sector. It should be noted that admissions for the non-Medicare population decreased for each year since 1981. Given this trend, some credit for lower admissions rates must go to changes in practice patterns and other factors not associated with Medicare policy.

A reduction in real expenditures per admission makes the greatest contribution to decreased spending growth. This decline is primarily due to smaller increases in payment rates under PPS since the very large increases in the first 2 years (1984 and 1985). At the previous rate of increase in Medicare expenditures per admission, the estimated growth in total inpatient spending between 1985 and 1991 would be 12.0 percent per year, rather than 5.1 percent. The

⁶The following section borrows heavily from a memorandum prepared by Sandra Christensen, of the Congressional Budget Office, February 4, 1991. Updated April 1992.

estimated real growth in spending per enrollee would have been 6.4 percent per year, rather than -0.3 percent.

Costs in hospital outpatient departments have dropped relative to the previous trend, indicating that hospital inpatient costs have not simply been shifted to the outpatient sector. Savings relative to trend for hospital outpatient and home health services may in large part reflect unsustainably large rates of growth during the trend period from 1975 through 1980. Introduction of a new payment methodology (a blend of a fixed rate and the hospital's costs) for certain surgical procedures performed in outpatient departments tended to reduce costs somewhat, but this effect was partially offset by the shift of services from the inpatient sector. During the 1980s, Medicare's administrative agents implemented stricter standards for determining coverage of home health services (tending to reduce costs), but increased demand for services from patients discharged earlier from hospitals than they would have been prior to the prospective payment system would have worked to increase Medicare's spending for home health.

Growth in spending for physicians' services has not slowed as much as hospital spending relative to previous trends despite the disproportionate impact on physicians of budget reconciliation bills. Apparently, growth in the volume of physicians' services has accelerated by enough to offset some of the enacted reductions in payment rates. Although not all of this growth was in response to fee cuts, growth in the volume of services was enough to completely offset the fee freeze in place from 1984 through 1986, but was insufficient to offset entirely the effects of subsequent fee cuts for "overvalued" procedures.

Spending for skilled nursing facilities (SNFs) increased significantly. During the period from 1975 through 1980, real spending per enrollee for SNFs was falling. This trend was reversed during the 1980s. In 1988, growth in SNF spending accelerated sharply because of a revision in the manual used by administrative agents to determine Medicare coverage that greatly relaxed the definition of covered care to make it conform with legislative language. Growth in SNF spending further accelerated in 1989 under provisions of the Medicare Catastrophic Coverage Act, which briefly eliminated the requirement for a hospital stay prior to a covered SNF stay and which reduced the copayments required of enrollees for SNF stays.

Table B-9 shows Medicare spending per enrollee in constant 1990 dollars where the CPI-U has been used to obtain constant dollars. The first column includes both Medicare benefits and administration. All other columns include spending on benefits only.

TABLE B-9.—REAL SPENDING PER ENROLLEE

[Fiscal years, in constant 1990 dollars]

Fiscal years	Medicare Bft+Adm	HI Bft	SMI BFT	Hospital inpatient	SNF	HH & Hos- pice	OPD	Physician & Lab	Hospital Inp+OPD
1967	648	470	134	449	18	4	3	130	451
1968	974	669	264	599	62	10	8	254	608
1969	1,138	792	293	721	62	12	13	276	735
1970	1,155	768	327	712	48	13	17	306	728
1971	1,194	818	315	779	32	12	21	289	800
1972	1,269	872	331	841	25	12	26	300	867
1973	1,244	861	324	831	23	12	25	294	856
1974	1,292	878	337	845	24	17	36	292	881
1975	1,479	1,030	382	989	27	21	54	321	1,043
1976	1,615	1,108	431	1,061	28	30	67	353	1,128
1977	1,756	1,208	484	1,156	28	35	80	393	1,236
1978	1,877	1,289	516	1,237	26	39	90	413	1,327
1979	1,941	1,317	557	1,264	25	42	98	445	1,362
1980	2,051	1,386	600	1,333	23	44	107	480	1,439
1981	2,216	1,501	650	1,447	21	46	117	521	1,563
1982	2,414	1,637	715	1,563	22	56	138	574	1,702
1983	2,565	1,710	795	1,620	24	66	152	642	1,772
1984	2,654	1,755	835	1,659	23	74	151	682	1,810
1985	2,876	1,921	885	1,821	22	80	159	725	1,980
1986	2,924	1,880	978	1,781	22	78	192	785	1,973
1987	3,002	1,829	1,110	1,735	23	72	215	894	1,950
1988	3,036	1,787	1,180	1,688	25	75	227	952	1,915
1989	3,133	1,845	1,215	1,691	75	81	241	972	1,932

ESTIMATES BY THE HEALTH CARE FINANCING ADMINISTRATION

1990 3,328 1,976 1,282 1,780 85 112 258 1,021 2,039
 1991 3,303 1,918 1,315 1,695 70 155 267 1,047 1,962
 1992 3,561 2,147 1,337 1,840 98 212 293 1,041 2,133

ESTIMATES BY THE CONGRESSIONAL BUDGET OFFICE

1993 3,734 2,286 1,371 1,889 134 264 319 1,050 2,208
 1994 3,993 2,439 1,477 1,971 160 311 351 1,124 2,322
 1995 4,216 2,546 1,593 2,032 171 345 387 1,204 2,419
 1996 4,421 2,624 1,720 2,078 178 371 430 1,287 2,507
 1997 4,865 2,926 1,860 2,307 198 424 476 1,381 2,782
 1998 5,117 3,036 2,002 2,392 203 444 527 1,472 2,919
 1999 5,410 3,176 2,154 2,510 207 463 588 1,562 3,098
 2000 5,729 3,327 2,323 2,638 211 483 660 1,659 3,298

AVERAGE ANNUAL GROWTH RATES (In percents)

1975-80 6.8 6.1 9.5 6.1 -3.4 16.3 14.7 8.4 6.7
 1980-85 7.0 6.7 8.1 6.4 -0.7 12.5 8.3 8.6 6.6
 1985-90 3.0 0.6 7.7 -0.4 31.0 7.1 10.2 7.1 0.6
 1990-95 4.8 5.2 4.4 2.7 15.0 25.2 8.4 3.3 3.5
 1995-2000 6.3 5.5 7.8 5.4 4.2 6.9 11.3 6.6 6.4

Notes.—Column 1 includes both benefits and administrative costs. All other columns include only benefits. The CPI-U was used to obtain constant dollars.

Source: Congressional Budget Office (February 1994).

From 1975 to 1985, total real spending per enrollee grew at an annual rate of 7.0 percent. From 1985 to 1990, there was a dramatic decline in the real growth rate in HI expenditures per capita due mostly to a drop in the inpatient hospital growth rate. This growth rate fell from 6.4 percent to -0.3 percent between the first 5 years of the 1980's and the subsequent years. While the outpatient growth rate increased slightly, the total real hospital spending growth rate declined from 6.5 percent annually to 0.7 percent between 1980 to 1985 as compared with 1985 to 1990. This decline in the hospital spending growth rate results in a 3.9 percentage point reduction in the total Medicare spending growth rate—a decline of 56 percent.

If the total growth rate in Medicare spending continued between 1985 and 1990 at the same 7.0 percent rate exhibited between 1980 and 1985, total Medicare costs per enrollee would be \$4,282 in 1991, or almost \$1,000 per enrollee more than the actual estimate. This would imply additional Medicare spending of about \$34 billion in that year.

TOTAL HEALTH CARE EXPENDITURES FOR THE ELDERLY

Expenditures for personal health care services for the elderly nearly quadrupled between 1977 and 1987, rising from \$43 billion to an estimated \$162 billion (see table B-10).

Government programs (Federal and State) account for two-thirds of estimated 1987 spending for the aged (see table B-10). The most significant of these programs is Medicare which pays for nearly half of the aged's health bill. Medicaid funds about 12 percent of the expenditures.

Health insurance coverage of the elderly

Table B-11 shows the sources of health insurance coverage for the noninstitutionalized population aged 65 and over in 1992. Over 95 percent of the aged population was enrolled in Medicare, and more than three-quarters of the Medicare enrollees had some form of supplemental coverage. Beneficiaries with incomes below the Federal poverty level were least likely to have supplemental coverage; those who had such coverage were more likely to rely on Medicaid. Higher income groups were more likely to obtain supplemental coverage through individually purchased medigap policies or through employer-based plans. Of those with incomes greater than 200 percent of the poverty level, 41.3 percent had employer coverage, compared to just 5.4 percent of those below poverty. (It should be noted that the Current Population Survey (CPS), on which table 11 is based, does not distinguish between primary and secondary sources of coverage. Some of the individuals reporting both Medicare and employer-based plans relied on the employer plan as their primary insurer, with Medicare functioning as a secondary payer.) About 3.6 percent of the elderly had more than one

TABLE B-10.—PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977, 1984, AND 1987

[In millions of dollars]

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total	43,425	18,906	7,782	10,696	6,041
Private	15,669	2,319	3,323	5,424	4,603
Consumer	15,499	2,263	3,320	5,352	4,564
Out-of-pocket	12,706	927	2,147	5,264	4,368
Insurance	2,793	1,336	1,173	88	195
Other private	170	56	3	72	39
Government	27,756	16,587	4,458	5,272	1,438
Medicare	19,171	14,087	4,158	348	578
Medicaid	6,049	733	232	4,453	631
Other government	2,536	1,767	68	470	230
1984					
Total	119,872	54,200	24,770	25,105	15,798
Private	39,341	6,160	9,827	13,038	10,316
Consumer	38,875	5,964	9,818	12,856	10,237
Out-of-pocket	30,198	1,694	6,468	12,569	9,467
Insurance	8,677	4,270	3,350	287	770
Other private	466	196	9	182	79
Government	80,531	48,040	14,943	12,067	5,482
Medicare	58,519	40,524	14,314	539	3,142
Medicaid	15,288	2,595	467	10,418	1,808
Other government	6,724	4,920	162	1,110	532
1987					
Total	162,000	67,900	33,500	32,800	27,800
Private	60,600	10,100	11,900	19,200	19,500
Government	101,500	57,900	21,600	13,600	8,300
Medicare	72,200	47,300	20,300	600	4,100
Medicaid	19,500	3,300	500	11,900	3,700

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-84." Health Care Financing Review, Fall 1984 No. 1, p. 1; and Waldo, Daniel R. et al. "Health Expenditures by Age Group, 1977 and 1987." Health Care Financing Review, Summer 1989, Vol. 10, No. 4 and errata reprint Fall 1989, Vol. 11, No. 1, p. 167.

TABLE B-11.—SOURCES OF HEALTH INSURANCE COVERAGE FOR THE NON-INSTITUTIONALIZED ELDERLY, BY RATIO OF INCOME TO POVERTY, 1992
[Population in thousands]

	Individuals with family income—						Total	
	Under 100 percent of poverty		100–199 percent of poverty		200 percent of poverty or more		Number	Percent
	Number	Percent	Number	Percent	Number	Percent		
Total Medicare	3,819	95.9	8,647	98.0	17,238	95.4	29,704	96.2
Medicare only	1,381	34.7	2,597	29.5	2,700	15.0	6,678	21.6
Medicare plus:								
Private supplement	961	24.1	3,395	38.5	5,739	31.7	10,095	32.7
Employer coverage	214	5.4	1,323	15.0	7,459	41.3	8,996	29.1
Medicaid	1,099	27.6	855	9.7	413	2.3	2,367	7.6
CHAMPUS	45	1.1	179	2.0	228	1.3	452	1.5
2 or more supplements	120	3.0	298	3.4	698	3.9	1,116	3.6
Insured through non-Medicare plan only	42	1.0	89	1.0	678	3.8	809	2.6
Uninsured	122	3.0	85	1.0	150	1.0	356	1.2
Total	3,983	100.0	8,822	100.0	18,065	100.0	30,870	100.0
Percent of all elderly		12.9		28.5		58.5		100.0

¹ Sample size too small for reliable estimates.

Source: CRS analysis of data from the March 1993 Current Population Survey.

source of supplemental coverage, such as both employer and individual medigap coverage, or both medigap and Medicaid. This figure does not include individuals who obtained multiple policies from a single basic coverage source, such as those who purchased more than one private medigap policy.

About 1.2 million elderly persons did not report Medicare coverage in 1992. Of these, 809,000 had coverage from some other source. An estimated 25 percent of these are Federal annuitants who are covered through the Federal Employees Health Benefits Program (this estimate is based on unpublished data from the Office of Personnel Management). Approximately 356,000 persons aged 65 or over were without health insurance coverage in 1992.

BACKGROUND DATA ON LONG-TERM CARE

The phrase "long-term care" refers to a broad range of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Chronic illnesses or conditions often result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of persons needing long-term care include the elderly and nonelderly disabled, persons with developmental disabilities (primarily persons with mental retardation), and persons with mental illness. This section of appendix B focuses on the elderly long-term care population.

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute medical illnesses, which occur suddenly and may be resolved in a relatively short period of time, chronic conditions last for an extended period of time and are not typically curable. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These conditions may include heart disease, strokes, arthritis, osteoporosis, and vision and hearing impairments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly.

The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care. For many individuals, their illness or condition does not result in a functional impairment or dependence and they are able to go about their daily routines without needing assistance. It is when the illness or condition results in a functional or activity limitation that long-term care services may be required.

The need for long-term care by the elderly is often measured by assessing limitations in a person's capacity to manage certain functions or activities. For example, a chronic condition may result in dependence in certain functions that are basic and essential for self-care, such as bathing, dressing, eating, toileting, and/or moving from one place to another. These are referred to as limitations in "activities of daily living," or ADLs. Another set of limitations, which reflect lower levels of disability, are used to describe difficulties in performing household chores and social tasks. These are referred to as limitations in "instrumental activities of daily living," or IADLs, and include such functions as meal preparation, clean-

ing, grocery shopping, managing money, and taking medicine. Limitations can vary in severity and prevalence, so that persons can have limitations in any number of ADLs or IADLs, or both.

Long-term care services are often differentiated by the settings in which they are provided. In general, services are provided either in nursing homes or in home and community-based care settings. Nursing home care includes a wide variety of services that range from skilled nursing and therapy services to assistance with such personal care functions as bathing, dressing, and eating. Nursing home services also include room and board. All of these services are considered to be formally provided services, in that they require persons to pay the facility for care that is provided.

Home and community-based care also includes a broad range of skilled and personal care services, as well as a variety of home management activities, such as chore services, meal preparation, and shopping. Home care services can be provided formally by home care agencies, visiting nurse associations, and day care centers. Home care is also provided informally by family and friends who are not paid for the services they provide. In contrast to nursing home care, which by necessity is formally provided care, most home and community-based care is provided informally by family and friends. Research has shown that more than 70 percent of those elderly persons living in the community and needing long-term care assistance rely exclusively on nonpaid sources of assistance for their care.

The long-term care population

Chart B-3 shows that an estimated 10.6 million persons of all ages require assistance with one or more ADLs or IADLs. About two-thirds of this total, or 7.1 million persons, are elderly. This is about one-quarter of the nation's elderly population.

Another 3.5 million persons under the age of 65 are limited in ADLs and/or IADLs. Some of these persons have congenital or developmental conditions such as cerebral palsy or mental retardation. Others are disabled from traumatic accidents or the onset of chronic conditions such as multiple sclerosis.⁷ It should be noted that these estimates do not adequately measure the need for long-term care among young children, since ADL and IADL limitations are not appropriate measures of their disabilities.

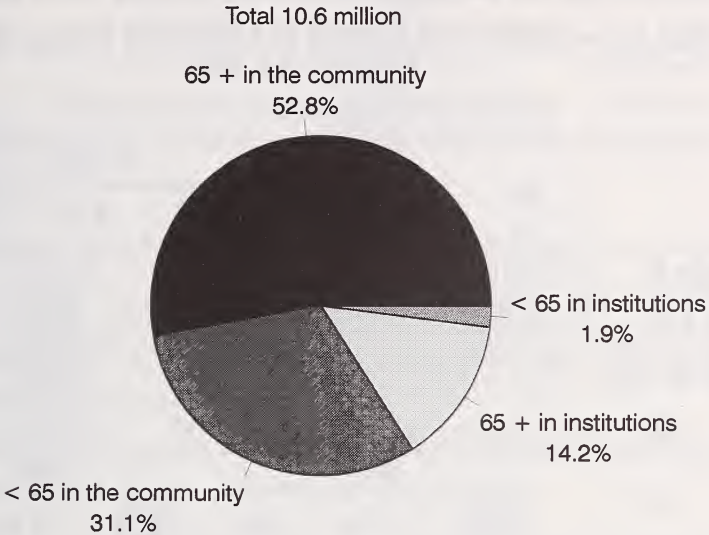
Chart B-3 also indicates that the great majority of persons with ADL and/or IADL limitations live in the community. Of the total disabled population, 84 percent live in the community. The nursing home population amounts to only 16 percent of the total, with the elderly by far the greatest share of this group.

Based on the projected growth of the elderly population in the future, major increases can be anticipated in the number of persons needing assistance with ADL and/or IADL limitations. Currently 32 million persons are 65 years of age and older. That number is expected to double to about 66 million by the year 2030. The 85+ population, the group at greatest risk of needing and using long-term care services, is expected to increase from 3.3 million persons

⁷ A Call for Action, p. 91.

in 1990 to 8.1 million in 2030.⁸ One study has estimated that the number of elderly needing assistance with ADLs and/or IADLs will grow from 7.1 million to 13.8 million by 2030, and the number requiring nursing home care will grow from 1.5 million to 5.3 million by that year.⁹

CHART B-3. PERSONS WITH ADL AND/OR IADL LIMITATIONS, 1990



Source: A Call for Action, The Pepper Commission, Final Report, September 1990. Based on Lewin/ICF Estimates Prepared for the Commission.

THE NURSING HOME POPULATION ¹⁰

Demographic characteristics

Analysis of the 1985 National Nursing Home Survey (NNHS) shows that the great majority of nursing home residents are 65 years of age and older. In 1985, 88 percent of residents were 65 years of age and older, and 12 percent were under the age of 65. As the top half of table 12 indicates, less than 5 percent of the total elderly population in the country were residents of nursing homes on any given day in 1985, and 0.1 percent of the under 65 population were residents in that year.

Although in the aggregate less than 5 percent of the total elderly population was in a nursing home on any given day in 1985,

⁸ U.S. Senate, Special Committee on Aging. "Aging America: Trends and Projections." November 1989. Sen. Prt. 101-59, p. 4.

⁹ A Call for Action, p. 108.

¹⁰ This material is drawn largely from "Characteristics of Nursing Home Residents and Proposals for Reforming Coverage of Nursing Home Care," by Richard Price, Richard Rinkunas, and Carol O'Shaughnessy, CRS Report for Congress, No. 90-471 EPW, September 24, 1990.

younger and older age groups of the elderly show very different rates of utilization. Table B-12 and chart 4 show that about 1 percent of the 65-74 age group and about 6 percent of the 75-84 age group resided in nursing homes in 1985. For the very old, those 85 and older, however, the incidence rate increases dramatically. In 1985, 22 percent of the 85 and older group resided in nursing homes. This group accounted for 40 percent of total nursing home residents, and 45 percent of the elderly nursing home population.

TABLE B-12.—NURSING HOME RESIDENTS AS A PROPORTION OF TOTAL POPULATION, BY AGE AND SEX, 1985

(All nursing home and U.S. population estimates in thousands)

Age	All residents		
	Nursing home pop.	U.S. pop.	Percent
Under 65	173	210,197	0.1
65 to 74	212	17,009	1.2
75 to 84	508	8,836	5.7
85 and older	597	2,695	22.1
65 and older	1,317	28,540	4.6
Total	1,490	238,737	0.6

Age	Males			Females		
	Nursing home pop.	U.S. pop.	Percent	Nursing home pop.	U.S. pop.	Percent
Under 65	89	104,623	0.1	84	105,574	0.1
65 to 74	81	7,475	1.1	132	9,534	1.4
75 to 84	141	3,293	4.3	367	5,543	6.6
85 and older	112	769	14.6	485	1,926	25.2
65 and older	334	11,537	2.9	984	17,003	5.8
Total	423	116,160	0.4	1,068	122,577	0.9

Note.—Figures are based on the number of current nursing home residents and U.S. Census Bureau estimates of the resident population. Figures do not reflect the likelihood of any individual being in a nursing home; rather these estimates indicate the percent of the total population that resided in nursing homes at a given point in time in 1985.

Source: Estimates prepared by CRS using the 1985 National Nursing Home Survey, Current Resident File, and U.S. Bureau of the Census, Current Population Report, United States Population Estimates, by Age, Sex and Race: 1980 to 1987, series P-25, No. 1022, March 1988. These estimates are subject to limitations of the data and methods employed.

Chart B-4 also illustrates that, among each of the age groups of the elderly, women were more likely to reside in nursing homes than men. For the elderly as a whole, women were twice as likely to be residing in nursing homes in 1985 as men (6 percent of women as opposed to 3 percent for men). The difference for men and women is particularly striking in the 75-84 and 85 and older age groups. Higher incidence rates for women, largely the result of longer life expectancies for women, mean a nursing home population that is predominately female. Chart B-5 indicates that 72 percent of nursing home residents were female in 1985.

CHART B-4. SHARE OF RESIDENT POPULATION IN NURSING HOMES, 1985

As a percent of total population

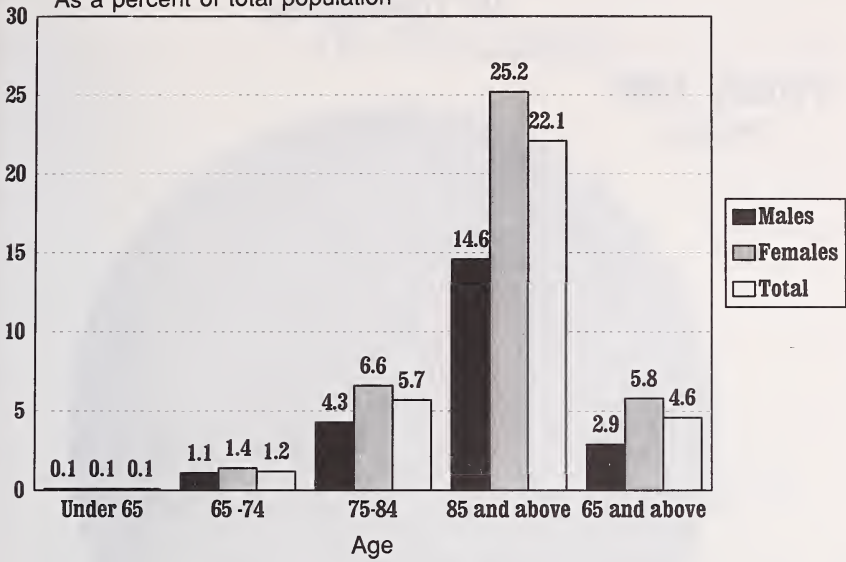
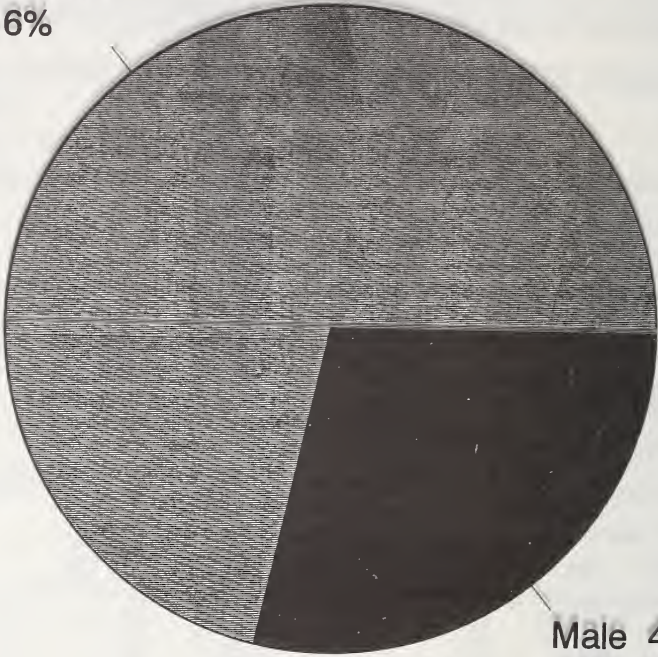


CHART B-5. DISTRIBUTION OF CURRENT RESIDENTS, BY SEX, 1985

(In Thousands)

Female 1,066
71.6%Male 423
28.4%

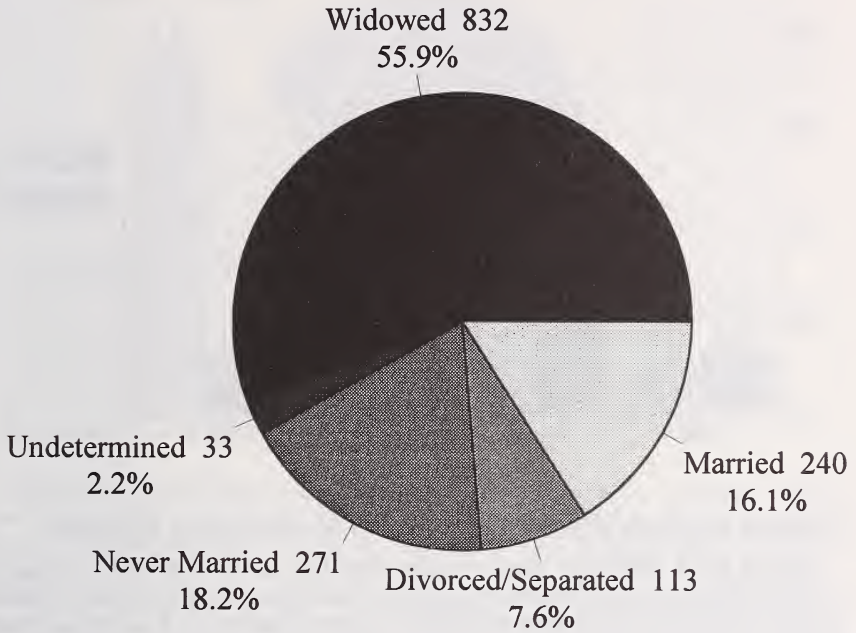
Studies have shown that persons without spouses are more likely to enter nursing homes than persons with spouses.¹¹ Because many disabled persons often require a great deal of assistance, spouses are often the only person outside of nursing homes able to provide such intensive care. Chart B-6 indicates that, at admission, only 16 percent of nursing home residents were married. Of the remaining, 56 percent were widowed, 18 percent had never been married, and about 8 percent were either divorced or separated.

Chart B-7 shows that, among the elderly, the proportion of residents who were married at admission decreases with age, and the proportion who were widowed increases.

¹¹"Financing of Long-Term Care." Submitted to the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services. Contract No. HHS-100-86-051, September 30, 1988. p. I-9.

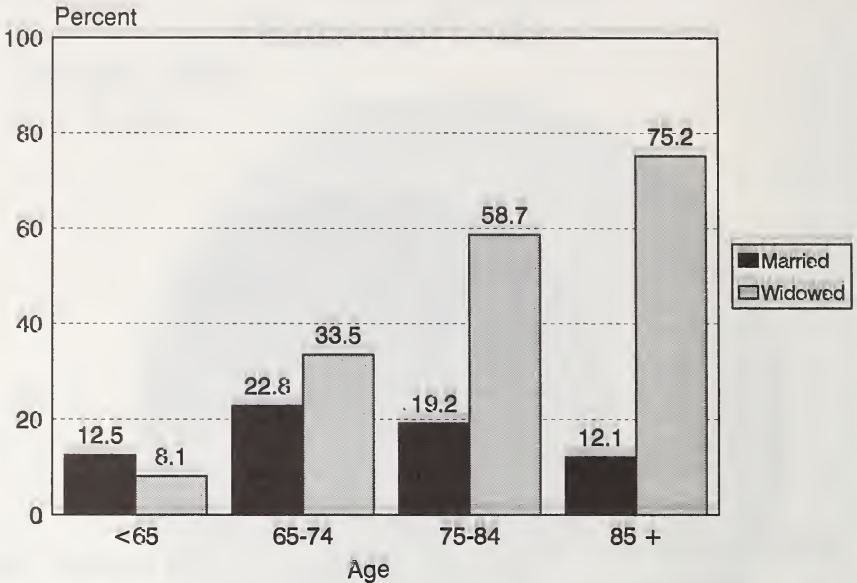
**CHART B-6. DISTRIBUTION OF CURRENT RESIDENTS, BY MARITAL STATUS AT
ADMISSION, 1985**

(In Thousands)



Total Residents = 1.5 million

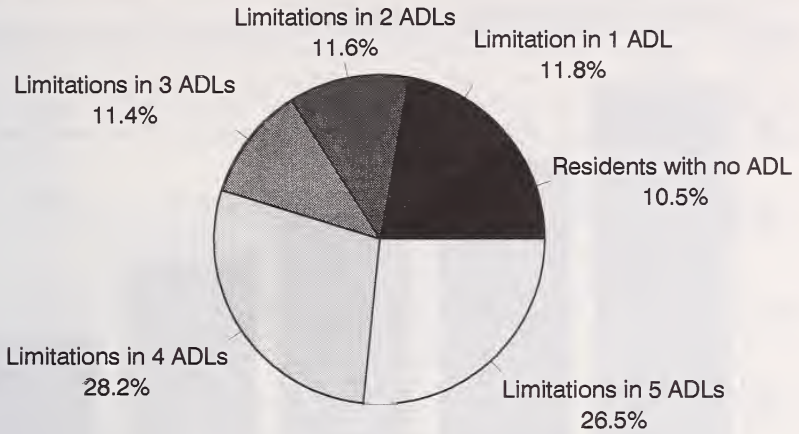
CHART B-7. PERCENT OF CURRENT RESIDENTS, MARRIED AND WIDOWED, BY AGE, 1985



Number and type of ADL limitations of nursing home residents

Chart B-8 presents data on the number of limitations in ADLs exhibited by nursing home residents of all ages in 1985. This figure shows that nursing home residents have substantial functional limitations. Seventy-eight percent of residents needed the assistance of others in two or more ADLs. Almost 55 percent of the nursing home population was severely impaired with four or more ADLs.

Chart B-8 also shows that slightly more than 20 percent of nursing home residents were judged to have no, or only one, activity limitation. A review of the diagnosis classifications of residents by their number of ADLs shows that residents whose primary diagnosis was a mental disorder were disproportionately represented among the total number of residents who had no activity limitation. About 35 percent of those with no ADLs had a mental disorder as their primary diagnosis. Mental disorders include a wide range of disabilities, including dementias, psychoses, and mental retardation. Persons with mental disorders but without limitations in ADLs may be residents of nursing homes because they require supervision or because of the unavailability of other housing and social service arrangements in the community.

CHART B-8. DISTRIBUTION OF CURRENT RESIDENTS BY NUMBER OF ADL LIMITATIONS, 1985

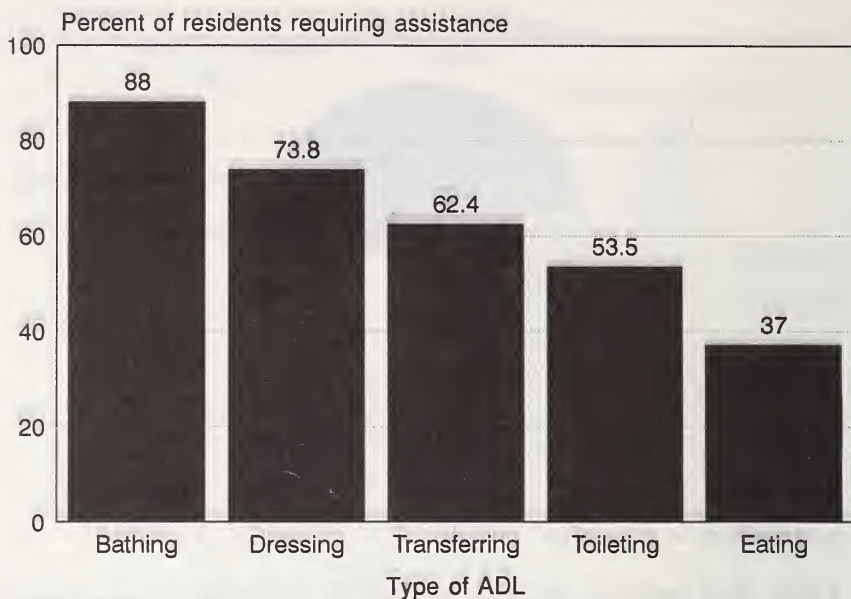
total residents = 1.5 million

Chart B-9 presents data on the extent to which nursing home residents have various kinds of limitations in ADLs. The most frequently found limitation among residents was bathing, with 88 percent of residents needing the assistance of another person. The least prevalent ADL was in eating, with slightly more than one-third of residents needing assistance with this ADL. About three-quarters of residents needed assistance to dress and two-thirds needed assistance in getting out of a bed or chair (transferring). About half of all residents needed the assistance of others in getting to the toilet or in caring for an ostomy bag or catheter.

In developing measures of functional limitations, researchers have found an ordered regression in functional abilities as part of the natural aging process. Loss of functioning begins with activities which are most complex and least basic, such as bathing or dressing. Functions which are least complex and most basic, such as feeding oneself, are retained longer. That is, persons are most able to retain their ability to feed themselves, but are less likely to retain their ability to bathe or dress without the assistance of others.¹² In addition, persons who are the most severely impaired are least likely to be able to eat independently, and therefore are more likely to have limitations in all the other ADLs. This ordered regression in stages of functioning is reflected in the nursing home population. As shown in chart B-9, higher proportions of residents needed assistance in bathing or dressing than those who needed assistance in eating.

¹²Katz, Sidney and Amechi Akpom. "A Measure of Primary Sociobiological Functions." *International Journal of Health Services*, Vol. 6, No. 3, 1976.

CHART B-9. PERCENT OF RESIDENTS REQUIRING ASSISTANCE OF ANOTHER PERSON IN PERFORMING ACTIVITY, 1985



Nursing home length of stay

The profile of nursing home residents presented above suggests a fairly homogeneous population: largely very elderly, female, widowed, and very disabled. However, an examination of length-of-stay patterns among the nursing home population suggests a more diverse group of persons using care than might be suggested by demographic data alone.

Analysis of discharge data from the NNHS shows at least two major users of nursing home care, as illustrated in charts B-10 and B-11. Chart B-10 portrays the distribution of persons discharged from nursing homes in 1984-85, according to their length of stay. Chart B-11 shows the distribution of days of care used by all discharged residents. It should be noted that the discharge file of the NNHS does not provide a comprehensive picture of the use of nursing home care by a single group of persons over time. As a result, estimates based on discharge survey data must be considered very general orders of magnitude of lengths of stay in a nursing home.

Chart B-10 shows that most nursing home stays are relatively short. About 52 percent of persons discharged from nursing homes had stays of less than 90 days and about 63 percent of persons discharged had stays of less than 6 months. In contrast, 27 percent of persons discharged had long stays of 1 year or longer, and 17 percent had stays of 2 years or longer.

The distribution of total days of care used by discharged residents is strikingly different. Chart B-11 shows that persons with

stays of less than 3 months accounted for only 4 percent of days of care. Those with stays of less than 6 months accounted for 8 percent of all days. On the other hand, persons with stays of 2 or more years accounted for about 73 percent of all discharge days. In other words, persons with short stays accounted for the majority of persons discharged from nursing homes, but very few of the days of care used. Those with long stays accounted for relatively few of those persons discharged from nursing homes, but the bulk of days used.

CHART B-10. DISTRIBUTION OF DISCHARGED RESIDENTS BY LENGTH OF STAY, 1984-85

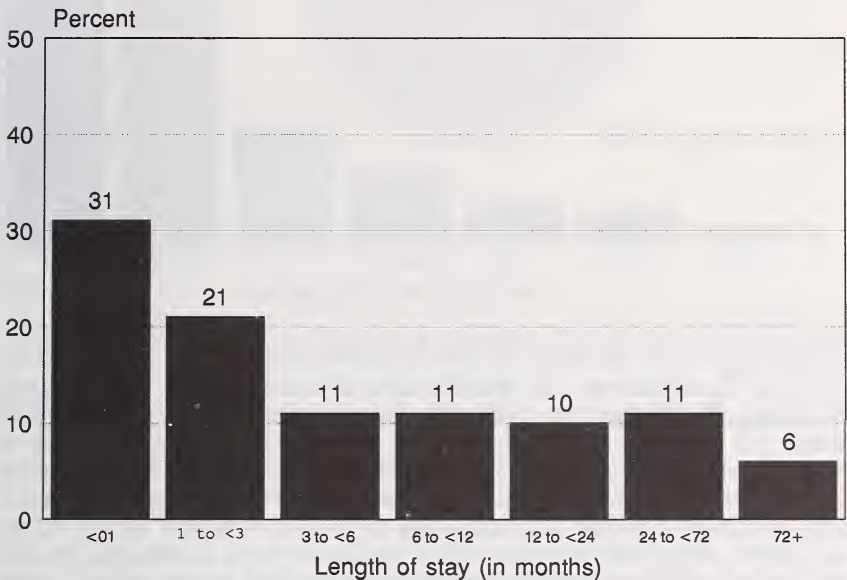
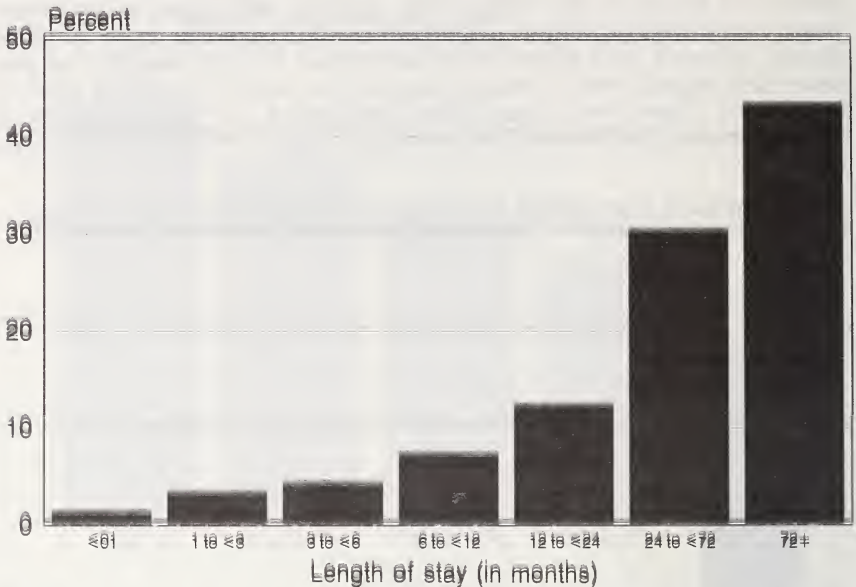


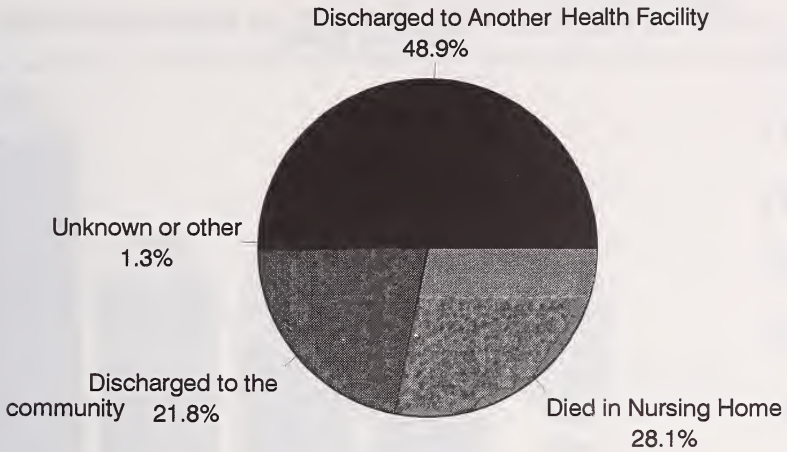
CHART B-11. DISTRIBUTION OF TOTAL DAYS USED BY DISCHARGED RESIDENTS, BY LENGTH OF STAY, 1984-85



Status of nursing home residents following discharge

Chart B-12 shows the distribution of residents by their status following discharge. In 1984-85, the largest share of persons—about 50 percent—were discharged from the nursing home to a hospital or other health care facility, including nursing homes (about 7 percent were discharged to another long-term care facility). About 28 percent of discharges were due to death in the nursing home. About 22 percent of the residents were discharged to the community. This mortality rate and the rate of return to the community may be conservative estimates. For example, 10 percent of those discharged from nursing homes to other health facilities died in these other facilities. Others are likely to have returned to the community.

CHART B-12. DISTRIBUTION OF DISCHARGED RESIDENTS BY LIVING ARRANGEMENT AFTER DISCHARGE, 1984-85



Total Residents = 1.2 Million

The community-based long-term care population

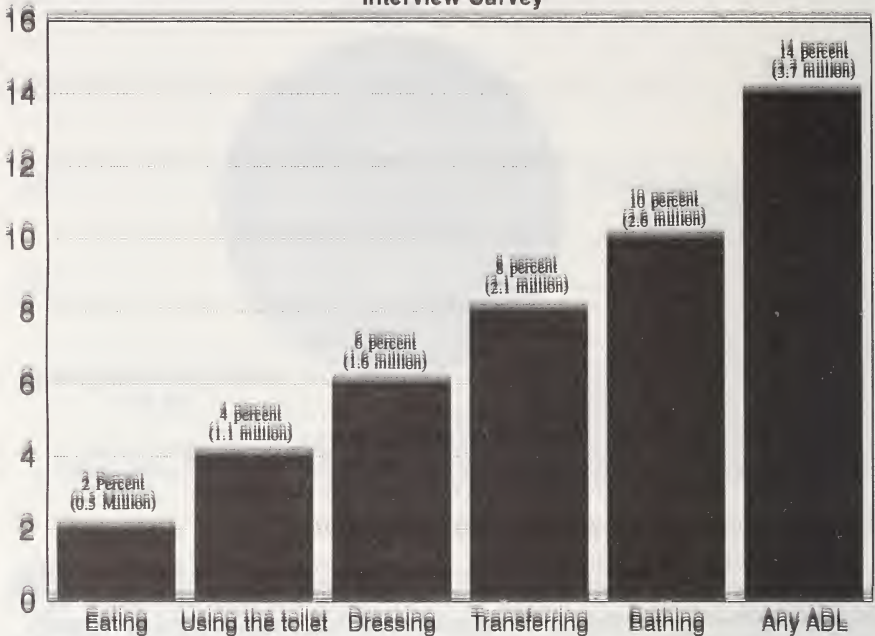
Chart B-13 below showed that the great majority of persons with ADL and/or IADL limitations live in the community. Almost 9 million persons of all ages, or 84 percent of the total population with ADL and/or IADL limitations, live in the community. The elderly represented almost 63 percent of this total.

Chart B-13 shows the number and percent of elderly persons living in the community with ADL limitations by type of limitation, as of 1984.¹³ A total of 3.7 million elderly persons living in the community, or 14 percent of the total elderly population, reported some limitation in their ability to bathe, transfer, dress, toilet, or eat. The prevalence of these ADLs forms a hierarchy similar to that shown above in chart B-8 for the nursing home population. The most prevalent limitation was in bathing, with 10 percent of the elderly reporting difficulty with this ADL. The least common was in eating, with 2 percent of elderly persons reporting difficulty.

¹³ Rowland, Diane. "Measuring the Elderly's Need for Home Care," *Health Affairs*, winter 1989, vol. 8, p. 42.

CHART B-13. PERCENT OF ELDERLY IN THE COMMUNITY WITH ADL LIMITATIONS, BY TYPE OF LIMITATION, 1984

Estimates based on the 1984 Supplement on Aging, National Health Interview Survey



Percent based on 26.4 million persons 65 years of older.

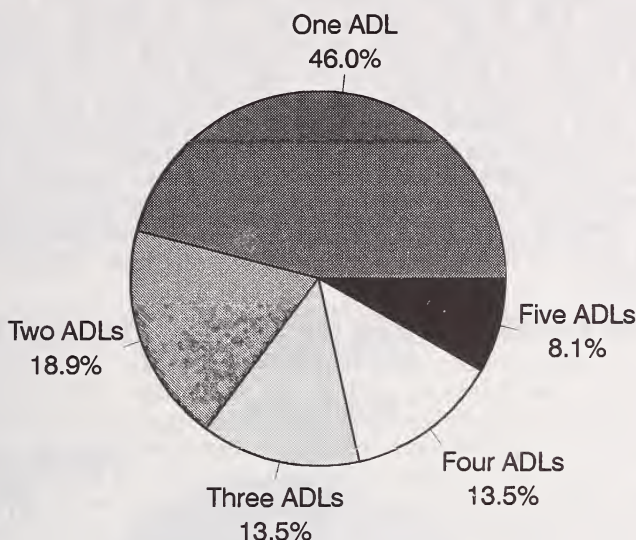
Source: Rowland, Diane. Health Affairs, v.8, p. 42 Measuring the Elderly's Need for Home Care.

Chart B-14 indicates that 54 percent of the elderly population with any kind of ADL limitation in 1984 had two or more ADLs. This was about 2 million persons. Almost 22 percent has 4 or 5 limitations. The severity of impairment is not uniform in the disabled population. Among the 2 million persons with two or more ADLs, 1.1 million reported some difficulty and 0.9 million reported a lot of difficulty or inability to perform at least two ADLs.¹⁴

¹⁴ Rowland, p. 43.

CHART B-14. DISTRIBUTION OF ADL'S AMONG NONINSTITUTIONALIZED ELDERLY POPULATION HAVING ONE OR MORE ADL LIMITATIONS, 1984

Estimates based on 1984 Supplement on Aging, National Health Interview Survey



Total = 3.7 million impaired persons 65 years or older

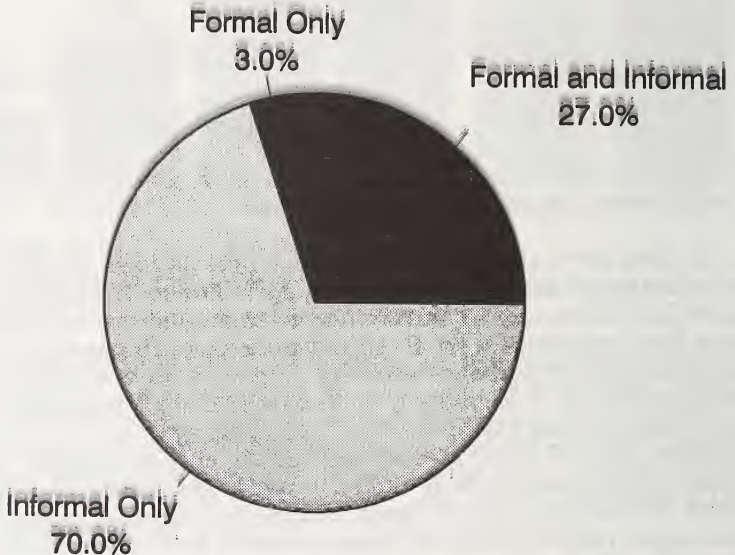
Studies have shown that the great bulk of care provided to persons living in the community with ADL and/or IADL limitations is provided informally by family and friends who are not paid for the care they provide. Chart B-15 indicates that 70 percent of severely disabled elderly persons receiving long-term care in the community relied solely on informally provided care. Only 3 percent relied only on formal or paid care.

More than 7 million spouses, adult children, other relatives, friends, and neighbors provided unpaid assistance to disabled elderly persons in 1984.¹⁵ Seven out of ten informal caregivers bear the major responsibility for care provided, and one of three is a sole provider. Three-quarters of all caregivers are female—wives and daughters of persons needing care. Research has shown that caregivers often reduce their work hours, take time off without pay, or quit jobs because of elder caregiving responsibilities. In addition, many caregivers are themselves elderly—one-quarter are between the ages of 65 to 74 and another 10 percent are 75 or older.

¹⁵ A Call for Action, p. 93-95. This discussion draws heavily on this report and research published by Robyn Stone, et al., "Caregivers of the Frail Elderly: A National Profile," *The Gerontologist*, vol. 27, 1987.

Use of formal, paid services by elderly persons living in the community is related to various characteristics of this group.¹⁶ Differences in functional status have been found to be strongly related to use of formal home and community-based care, with the likelihood of using any formal service increasing as levels of impairment increase. Age is also linked to the use of formal services, largely explained by the fact that age is associated with decreasing functional status. In general and in each age group of the elderly, more women use formal home and community-based care services than men. This is related to the longer life expectancies of women. Persons living alone are more than twice as likely to use formal services as compared to those living with other persons. In addition, the amount of money spent on home care services has been found to be directly related to income; that is, out-of-pocket expenses for home care increase substantially as median family income increases.¹⁷

CHART B-15. SOURCE OF HOME CARE SERVICES FOR THE SEVERELY DISABLED ELDERLY POPULATION, 1989



Note: Severely disabled refers to those persons with three or more ADL limitations.

Source: Lewin/ICF and the Brookings Institution, 1989 estimates based on National Long-Term Care Survey, 1982.

¹⁶ This material is drawn largely from Short, Pamela and Joel Leon, "Use of Home and Community Services by Persons Ages 65 and Older with Functional Difficulties," National Medical Expenditure Survey, Research Findings 5, Department of Health and Human Services, Agency for Health Care Policy and Research, September 1990, p. 7-9.

¹⁷ Liu, Korbin, Kenneth Manton, and Barbara Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review, Winter 1985, vol. 7, No. 2, p. 55.

Public and private spending for long-term care

Table B-13 indicates that sizable public and private funds are being spent on long-term care services. For two major categories of long-term care services, nursing home and home care, total national spending amounted to almost \$107.8 billion in 1993. This total is for all age groups using long-term care. By far the greatest portion of spending is for nursing home care. About \$75 billion, or 70 percent of the total, was spent for nursing home care in 1993.

Public programs paid about 60 percent of the Nation's total nursing home bill. Medicaid payments accounted for almost all of this amount. Medicaid is the Federal-State health program for the poor and for those who have become poor as the result of incurring large medical care expenses. In 1993, Medicaid spending for nursing home care amounted to 48 percent of total national nursing home spending.

Table B-13 shows that private spending accounted for about \$30 billion, or the remaining 40 percent of national spending. Nearly all private spending for nursing home care was paid directly by consumers out-of-pocket with income and/or accumulated resources. Private insurance coverage for long-term nursing home care is very limited, with private insurance payments amounting to 0.1 percent of total spending for nursing home care in 1993.

Spending for home health care services amounted to \$33 billion, or 30 percent of the total. Public programs accounted for about 72 percent of total home health care spending. Out-of-pocket payments accounted for almost all of private spending, private insurance again being very limited for this care. Most home and community-based care, as discussed above, is provided by family and friends who are not paid for the services they provide.

Major Federal programs supporting long-term care

Five programs represent the major source of Federal financial support available for nursing home and community-based long-term care—Medicaid, Medicare, the Social Services Block Grant (SSBG), the Older Americans Act, and the Supplemental Security Income (SSI) program. None of these programs supports the full range of long-term care services. Certain programs provide health services but exclude social services. Others provide strictly social services. Some have income eligibility requirements, others do not.

Medicaid is the Nation's major program of financial support for long-term care, principally because of its coverage of nursing home care. Medicaid payments for nursing home care (excluding nursing homes for the mentally retarded) amounted to about 27 percent of total Medicaid spending in fiscal year 1991. Comparatively little funding is devoted to home and community-based care. Coverage of both nursing home and home and community-based services is restricted to those persons who have limited income and assets. In general, Medicaid rules limit eligibility to those persons who qual-

ify for cash welfare assistance or who incur large health care expenses that deplete their income and assets.¹⁸

TABLE B-13.—ESTIMATED LONG-TERM CARE SPENDING FOR ALL AGE GROUPS, BY SOURCE, 1993

[Dollars in billions]

Source of spending	Amount
Nursing home care:	
Medicaid	\$36.3
Medicare	5.7
Other Federal	1.0
Other State	2.5
Out-of-pocket payments and other	29.6
Private insurance	0.1
Total	75.2
Home health care:	
Medicaid	7.4
Medicare	10.1
Other Federal programs	1.6
Other State	4.5
Out-of-pocket payments and other	8.9
Private insurance	0.1
Total	32.6
Total long-term care expenditures	107.8

Source: Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy, Department of Health and Human Services.

Medicare, the Federal health insurance program for the elderly and disabled, is focused primarily on coverage for acute health care costs and was never envisioned to provide protection for long-term care. Coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those persons who demonstrate a need for daily skilled nursing care following a hospitalization. Many persons who require long-term nursing home care do not need daily skilled nursing care, and therefore, do not qualify for Medicare's benefit. As a result of this restriction, Medicare paid for about 7.6 percent of the Nation's expenditures for nursing home care in 1993.

For similar reasons, Medicare pays for only limited amounts of community-based long-term care services; primarily through the program's home health benefit. To qualify for home health services, the person must be in need of skilled nursing care on an intermittent basis, or physical or speech therapy. Most chronically impaired persons do not need skilled care to remain in their homes, but

¹⁸ Most States extend Medicaid eligibility to persons who qualify for welfare benefits under the Supplemental Security Income (SSI) program. SSI requires that persons have assets that do not exceed \$2,000 and income that does not exceed \$446 per month in 1994.

rather nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel.

Three other Federal programs—SSBG, the Older Americans Act, and the SSI program—provide support for community-based long-term care services for impaired elderly persons. The SSBG provides block grants to the States for a variety of home-based services for the elderly as well as the disabled and children. The Older Americans Act also funds a broad range of in-home services for the elderly. Under the SSI program, the federally administered income assistance program for aged, blind, and disabled persons, many States provide supplemental payments to the basic SSI payment to support selected community-based long-term care services for certain eligible persons, including the frail elderly. However, since funding available for these three programs is limited, their ability to address the financing problems in long-term care is also very limited.

Spending down for Medicaid coverage of nursing home care

As discussed above, the Medicaid program is the major public source of support for the cost of nursing home care. Its spending for nursing home care is driven largely by its coverage of persons who are not initially poor but who become poor by depleting their assets on the cost of care. At an average cost of \$35,000 a year, nursing home costs can quickly deplete the resources of an elderly individual, especially after prolonged stays, and these costs also exceed the monthly income of most persons. The depletion of financial resources on the cost of care and the movement from private payment for care to Medicaid coverage is referred to as the "spend-down" process. In 1991, Medicaid nursing home payments for elderly persons who spent down amounted to 60 percent of total Medicaid payments for all services for all elderly beneficiaries.¹⁹

Numerous studies have looked at Medicaid spend-down in the last 5 years. A recent review of these studies, "A Synthesis and Critique of Studies on Medicaid Asset Spenddown" by Adams, Meiners and Burwell, found that they generally use two different measures of Medicaid asset spenddown.²⁰ One method measures the percentage of persons originally admitted to nursing homes as private payers who eventually convert to Medicaid prior to final discharge.

¹⁹ Spending down under Medicaid is a two-step process. First persons must meet the resources or assets test. The term "resources" generally refers to liquid assets such as cash on hand, savings and checking accounts, stocks and bonds, etc. In order to become eligible for Medicaid, the value of the individual's available resources must be less than a State-determined dollar standard, usually \$2,000 for an individual without a spouse, the level used for the SSI program. Certain items, such as the house, are excluded as countable resources under SSI and Medicaid rules. Second, after an individual has depleted virtually all accumulated resources on the cost of nursing home care, or has transferred resources (for less than fair market value) prior to the time when eligibility could be denied because of the transfer, income standards are then considered. Most States have no absolute upper limit on income for applicants residing in nursing homes. These States have what are known as medically needy programs. As long as the applicant's current monthly income is insufficient to cover medical expenses, including the cost of care in the nursing home, the applicant can become eligible for Medicaid. Other States use a special income level to determine eligibility for persons residing in nursing homes. Like the medically needy, these persons have income in excess of cash welfare program standards. By Federal law, the special income level used by States can be no more than three times the basic SSI payment level, or \$1,302 in 1993. This rule is known as the "300 percent rule."

²⁰ This material draws heavily on Adams, E. Kathleen, Mark Meiners, and Brian Burwell, "A Synthesis and Critique of Studies on Medicaid Asset Spenddown," Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, January 1992.

This method is a measure of the risk to individuals of spending down to Medicaid over the course of their lifetimes, given the probability they enter a nursing home as private payers.

A second method of measuring Medicaid spenddown examines the percentage of Medicaid residents of nursing homes who were not eligible for Medicaid when they were originally admitted. This method can be useful in capturing the proportion of State Medicaid expenditures for nursing home care that is accounted for by those who spend down.

The review of spenddown studies, which use several different national and State-level data bases, found widely varying estimates of spenddown as measured by these two methods. According to the review, the critical factor explaining differences among these studies is the length of time that persons are studied. The proportion of persons spending down during a single stay is much lower than the proportion of persons who spend down over their entire lifetime, since half or more of persons using nursing home care have multiple stays. In general, studies using national data tend to show lower estimates of spenddown than do State studies that tend to observe people over longer time intervals.

The review of spenddown studies found that between 20 and 25 percent of persons who originally enter nursing homes as private payers convert to Medicaid before final discharge. For this method of measuring spenddown, not enough State studies exist to determine the extent to which spenddown rates vary from State to State.

On the other hand, estimates of spenddown as measured by the percentage of Medicaid residents of nursing homes who were not eligible for Medicaid when they were originally admitted vary considerably across States, reflecting variations in Medicaid eligibility policies across the States as well as other factors. Studies measuring spenddown according to this method have found spenddown rates of 27 percent for Michigan, 31 percent for Wisconsin, and 39 to 45 percent for Connecticut.

Spenddown studies have also examined the length of time it takes for persons to spend down after nursing home admission. The results of these studies reveal that of those people who spend down, the majority spend down within a year of nursing home admission. This finding suggests that most people who spend down have limited assets when they first enter a nursing home.

Certain State studies also show that people who spend down to Medicaid spend more time on Medicaid after converting to Medicaid coverage than they spend as private payers prior to conversion. The studies show that Medicaid-paid days account for at least 65 to 75 percent of all nursing home days used by those who spend down. However, the research also shows that, once eligible for Medicaid, people who spend down pay a greater proportion of total nursing home costs, through contributions of their income they are required to make before Medicaid makes its payment, than persons who are eligible for Medicaid at initial admission. As a result, people who spend down account for a somewhat lower percentage of total Medicaid expenditures than their percentage of Medicaid-covered nursing home days.

Private long-term care insurance

Private long-term care insurance is generally considered to be the most promising private sector option for providing the elderly additional protection for long-term care expenses. Long-term care insurance is a relatively new, but rapidly growing, market. In 1986, approximately 30 insurers were selling long-term care insurance policies of some type and an estimated 200,000 persons were covered by these policies. By 1987, a Department of Health and Human Services Task Force on Long-Term Care Insurance found 73 companies writing long-term care insurance policies covering 423,000 persons. As of December 1992, the Health Insurance Association of America found that more than 2.9 million policies had been sold, with 135 insurers offering coverage. (Note that this is a cumulative total of policies sold; fewer persons would be covered, due to failure to pay premiums because of death, a change in income, a decision not to continue coverage, etc.)

Although growth has been considerable in a short period of time, the private insurance industry has approached this potential market with caution. Insurers are concerned about the potential for adverse selection in long-term care insurance, where only those persons likely to need care actually buy insurance. In addition, they point to the problem of induced demand for services that can be expected to be generated by the availability of new long-term care insurance. With induced demand, sometimes also referred to as moral hazard, individuals decide to use more services than they otherwise would because they have insurance and/or will shift from nonpaid to paid providers for their care. In addition, insurers are concerned that, given the nature of many chronic conditions, persons who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

As a result of these risks, insurers have designed policies that limit their liability for paying claims. Policies have been medically underwritten to exclude persons with certain conditions or illnesses. They have contained benefit restrictions that limit access to covered care. Policies also limit the period of coverage they offer, typically to a maximum of 4 or 5 years. In addition, most plans provide indemnity benefits that pay only a fixed amount for each day of coverage service. If these amounts are not updated for inflation, the protection offered by the policy can be significantly eroded by the time a person actually needs care. Today payment amounts can generally be updated for inflation, but only with significant increases in premium costs.

These design features of long-term care insurance raise issues about the quality of coverage offered purchasers of policies. The insurance industry has responded to some of these concerns by offering new products that provide broadened coverage and fewer restrictions. One of the key issues outstanding in the debate on the role private insurance can play in financing long-term care is the affordability of coverage. The Health Insurance Association of America has reported that policies paying \$80 a day for nursing home care and \$40 a day for home health care with inflation protection and a 20-day deductible period and a 4-year maximum coverage period had an average annual premium in December 1992 of

\$1,597 when purchased at the age of 65 and \$5,334 when purchased at the age of 79. Many elderly persons cannot afford these premiums.

The insurance industry believes that affordability of premiums can be greatly enhanced if the pool of persons to whom policies are sold is expanded. The industry has argued that the greatest potential for expanding the pool of persons buying coverage and reducing premiums lies with employer-based group coverage. Premiums should be lower in employer-based group coverage because younger age groups with lower levels of risk of needing long-term care would be included, allowing insurance companies to build up reserves to cover future payments of benefits. In addition, group coverage has lower administrative expenses.

As of December 1992, 506 employers offered a long-term care insurance plan to their employees. These employer-based plans covered over 350,000 employees, their spouses, retirees, parents, and parents-in-law.

But just how broadly based employer interest is in a new long-term care benefit is unclear at the present. Many employers currently face large unfunded liabilities for retiree pension and health benefits. Also, many employers have recently experienced substantial increases in premiums for their current health benefits plans. Very few employers contribute to the cost of a long-term care plan. Most employers require that the employee pay the full premium cost of coverage. In contrast, the majority of medium and large sized employers pay the full premium cost of regular health care benefits for their employees.

APPENDIX C. NATIONAL AND INTERNATIONAL HEALTH CARE EXPENDITURES AND HEALTH INSURANCE COVERAGE

NATIONAL HEALTH EXPENDITURES

During 1965 (the year prior to the beginning of the Medicare and Medicaid programs) national health expenditures were \$41.6 billion; by 1993 annual expenditures were \$898 billion, over 21 times that amount (see table 1). Hospital care expenditures are the largest component of national health expenditures, representing 38 percent of total national health spending in 1993. In terms of per capita spending, \$1,101 was spent for hospital care in 1991, compared to \$681 in 1985, an increase of 62 percent over 6 years (see table 3).

Adjusting for inflation, health care expenditures have still increased substantially, rising from \$179.9 billion in 1965 (in constant 1991 dollars) to \$751.8 billion in 1991, an increase of about 318 percent (see table 2). The largest increases occurred between 1965 and 1970 (45 percent) and 1985 to 1991 (41 percent). The annual rate of increase in inflation-adjusted per capita expenditures from 1980 to 1985 was 4.8 percent. For the years 1986 to 1991, the comparable rate was 5.4 percent.

Of the various sources of payment for personal health care expenditures in 1993, private health insurance was the largest (see table 5). In 1993, private health insurance payments (including premiums paid for both employers and employees) were \$289 billion and accounted for 32 percent of all payments for personal health care. The Federal Government accounted for 31 percent (\$280 billion) of personal health spending (including payments for both Medicare and Medicaid), 14.5 percent (\$130 billion) was paid by State and local sources, and 18 percent (\$162 billion) was paid by direct (out-of-pocket) payments by individuals. Philanthropy and in-plant health services accounted for 4.1 percent.¹

¹ Personal health expenditures accounted for 88 percent of national health expenditures in 1991. The remaining 12 percent was expended on program administration; administrative costs of private health insurance and profits earned by private health insurance; noncommercial health research; new construction; and government public health activities.

TABLE C-1.—NATIONAL HEALTH EXPENDITURES: AGGREGATE AMOUNTS FOR SELECTED CALENDAR YEARS 1960-93

[Dollar amounts in billions]

	1960	1965	1970	1975	1980	1985	1990	1991	1993	2000 ¹
Total	\$27.1	\$41.6	\$74.4	\$132.9	\$250.1	\$422.6	\$675.0	\$751.8	\$898	\$1,613
Percent of GNP	5.3	5.9	7.4	8.4	9.2	10.5	12.2	13.2	(1)	(1)
Health services and supplies	\$25.4	\$38.2	\$69.1	\$124.7	\$238.9	\$407.2	\$652.4	\$728.6	(1)	(1)
Personal health care	23.9	35.6	64.9	116.6	219.4	369.7	591.5	660.2	(1)	(1)
Hospital care	9.3	14.0	27.9	52.4	102.4	168.3	258.1	288.6	340	604
Physicians' services	5.3	8.2	13.6	23.3	41.9	74.0	128.8	142.0	168	315
Dentists' services	2.0	2.8	4.7	8.2	14.4	23.3	34.1	37.1	43	69
Other professional services .....	.6	.9	1.5	3.5	8.7	16.6	30.7	35.8	47	110
Home health care .....	.0	.1	.1	.4	1.3	3.8	7.6	9.8	18	47
Drugs and other medical nondurables	4.2	5.9	8.8	13.0	21.6	36.2	55.6	60.7	70	112
Vision products and other medical durables .....	.8	1.2	2.0	3.1	4.6	7.1	11.7	12.4	14	23
Nursing home care	1.0	1.7	4.9	9.9	20.0	34.1	53.3	59.9	74	138
Other personal health care .....	.7	.8	1.4	2.7	4.6	6.4	11.5	14.0	18	34
Program administration and net cost of private health insurance	1.2	1.9	2.8	5.1	12.2	25.2	38.9	43.9	(1)	(1)
Government public health activities .....	.4	.6	1.4	3.0	7.2	12.3	22.0	24.5	(1)	(1)
Research, and construction of medical facilities	1.7	3.5	5.3	8.3	11.3	15.4	22.7	23.1	(1)	(1)

¹ Estimates prepared by the Congressional Budget office.

Note: Numbers may not add to totals due to rounding.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

TABLE C-2.—NATIONAL HEALTH EXPENDITURES IN CONSTANT 1991 DOLLARS, FOR SELECTED CALENDAR YEARS 1960-91

[Dollar amounts in billions]

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989	1990	1991
Total	\$125.0	\$179.9	\$251.1	\$335.6	\$413.4	\$534.9	\$565.3	\$597.5	\$628.7	\$653.8	\$703.4	\$751.8
Health services and supplies	117.2	165.0	242.4	315.6	394.8	515.4	545.5	571.8	605.9	641.1	679.8	728.6
Personal health care	110.1	154.0	227.8	295.1	362.6	468.0	498.1	526.7	555.8	583.2	616.3	660.2
Hospital care	42.7	60.7	98.0	132.6	169.3	213.0	223.4	232.9	244.1	255.2	268.9	288.6
Physicians' services	24.3	35.4	47.7	58.9	69.2	93.6	102.0	111.5	121.0	127.5	134.3	142.0
Dentists' services	9.0	12.1	16.4	20.9	23.7	29.4	30.7	32.5	33.9	34.8	35.5	37.1
Other professional services	2.8	3.7	5.3	8.9	14.4	21.0	23.1	25.4	27.4	29.7	32.0	35.8
Home health care .....	.2	.3	.5	1.0	2.2	4.9	5.0	4.9	5.2	6.2	7.9	9.8
Drugs and other medical nondurables	19.6	25.5	30.9	33.0	35.7	45.8	49.4	51.7	53.3	55.4	58.0	60.7
Vision products and other medical durables	3.7	5.4	7.1	7.8	7.5	9.0	10.0	10.9	11.7	11.4	12.2	12.4
Nursing home care	4.5	7.3	17.1	25.2	33.0	43.2	45.6	47.6	49.3	52.2	55.6	59.9
Other personal health care	3.2	3.6	4.8	6.9	7.5	8.1	8.8	9.3	10.1	10.7	12.0	14.0
Program administration and net cost of private health insurance	5.4	8.3	9.7	12.8	20.2	31.9	30.6	27.6	30.9	37.1	40.6	43.9
Government public health activities	1.7	2.7	4.9	7.7	11.9	15.6	16.8	17.5	19.1	20.8	22.9	24.5
Research, and construction of medical facilities	7.8	14.9	18.7	21.0	18.6	19.5	19.8	20.7	22.8	22.7	23.6	23.1

Note: Constant dollar expenditures are calculated using the consumer price index for all urban consumers (CPI-U).

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

TABLE C-3.—NATIONAL HEALTH EXPENDITURES: PER CAPITA AMOUNTS FOR SELECTED CALENDAR YEARS 1960-91

[Dollar amounts per capita]

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989	1990	1991
Total	\$143	\$204	\$346	\$592	\$1,064	\$1,711	\$1,824	\$1,962	\$2,146	\$2,352	\$2,601	\$2,868
Health services and supplies	134	187	322	555	1,016	1,648	1,760	1,893	2,068	2,271	2,513	2,779
Personal health care	126	175	302	519	933	1,497	1,607	1,744	1,898	2,066	2,279	2,518
Hospital care	49	69	130	233	436	681	721	771	833	904	994	1,101
Physicians' services	28	40	63	104	178	299	329	369	413	452	496	542
Dentists' services	10	14	22	37	61	94	99	108	116	123	131	141
Other professional services	3	4	7	16	37	67	75	84	93	105	118	137
Home health care	0	0	1	2	6	16	16	16	18	22	29	37
Drugs and other medical nondurables	22	29	41	58	92	146	159	171	182	196	214	231
Vision products and other medical durables	4	6	9	14	19	29	32	36	40	41	45	47
Nursing home care	5	8	23	44	85	138	147	157	168	185	205	229
Other personal health care	4	4	6	12	19	26	28	31	34	38	44	53
Program administration and net cost of private health insurance	6	9	13	23	52	102	99	91	106	131	150	167
Government public health activities	2	3	6	14	31	50	54	58	65	74	85	94
Research, and construction of medical facilities	9	17	25	37	48	62	64	69	78	80	87	88

Note: Numbers may not add to totals due to rounding.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

TABLE C-4.—NATIONAL HEALTH EXPENDITURES: PER CAPITA AMOUNTS, IN CONSTANT 1991 DOLLARS, FOR SELECTED CALENDAR YEARS 1960-91
[Dollar amount per capita]

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989	1990	1991
Total	\$658	\$882	\$1,216	\$1,499	\$1,758	\$2,165	\$2,266	\$2,352	\$2,471	\$2,583	\$2,710	\$2,868
Health services and supplies	616	809	1,129	1,406	1,679	2,086	2,187	2,270	2,381	2,495	2,619	2,779
Personal health care	579	755	1,061	1,314	1,542	1,894	1,997	2,091	2,185	2,269	2,374	2,518
Hospital care	225	298	457	591	720	862	886	924	959	993	1,036	1,101
Physicians' services	128	174	222	262	294	379	409	443	476	496	517	542
Dentists' services	48	59	76	93	101	119	123	129	133	135	137	141
Other professional services	15	18	25	40	61	85	93	101	108	116	123	137
Home health care	1	1	2	5	9	20	20	20	20	24	30	37
Drugs and other medical nondurables	103	125	144	147	152	185	198	205	209	216	223	231
Vision products and other medical durables	20	26	33	35	32	37	40	43	46	45	47	47
Nursing home care	24	36	80	112	141	175	183	184	194	203	214	229
Other personal health care	17	17	22	31	32	33	35	37	40	42	46	53
Program administration and net cost of private health insurance	28	41	45	57	86	129	123	109	122	144	156	167
Government public health activities	9	13	23	34	51	63	67	69	75	81	88	94
Research, and construction of medical facilities	41	73	87	93	79	79	80	82	90	88	91	88
Average annual [percentage increase]	60-65	65-70	70-75	75-80	80-85	60-90	85-90	89-90	90-91			
Total	6.0	6.6	4.3	3.2	4.3	4.8	4.6	4.9	5.8			
Health services and supplies	5.6	6.9	4.5	3.6	4.4	4.9	4.7	5.0	6.1			
Personal health care	5.4	7.1	4.4	3.3	4.2	4.8	4.6	4.6	6.1			
Hospital care	5.8	8.9	5.3	4.0	3.7	5.2	3.7	4.3	6.3			
Physicians' services	6.3	5.0	3.4	2.3	5.2	4.8	6.4	4.3	4.7			

Note: Constant dollar expenditures are calculated using the consumer price indices for all urban consumers (CPI-U). Average annual amounts are calculated on unrounded numbers.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

TABLE C-5.—PERSONAL HEALTH CARE EXPENDITURES: AGGREGATE AMOUNTS AND PERCENTAGE DISTRIBUTION FOR SELECTED CALENDAR YEARS
1960-93

	1960	1965	1970	1975	1980	1985	1990	1991	1993 ¹	2000 ¹
	Amount in billions of dollars									
Total	\$23.9	\$35.6	\$64.9	\$116.6	\$219.4	\$369.7	\$591.5	\$660.2	\$898	\$1,069
Private	18.8	28.4	42.5	71.3	132.3	221.5	349.2	377.0	411	789
Private health insurance	5.0	8.7	15.2	29.9	65.3	114.2	191.2	209.3	200	519
Out of pocket	13.3	19.0	25.6	38.5	59.5	94.4	136.5	144.3	162	246
Other private sources of funds .....	.4	.7	1.7	2.9	7.6	12.9	21.5	23.4	37	59
Public	5.1	7.3	22.4	45.3	87.1	148.2	242.3	283.3	411	789
Federal	2.1	3.0	14.6	31.0	63.5	111.7	177.0	204.1	280	555
State and local	3.0	4.3	7.8	14.4	23.6	36.6	65.3	79.1	130	234
	Percentage distribution									
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	78.6	79.6	65.4	61.1	60.3	59.9	59.0	57.1	54.3	51.1
Private health insurance	21.0	24.3	23.4	25.6	29.7	30.9	32.3	31.7	32.2	32.1
Out of pocket	55.9	53.4	39.5	33.1	27.1	25.5	23.1	21.9	18.0	15.2
Other private sources of funds	1.7	1.9	2.6	2.5	3.5	3.5	3.6	3.6	4.1	3.7
Public	21.4	20.4	34.6	38.9	39.7	40.1	41.0	42.9	45.7	48.9
Federal	8.9	8.3	22.6	26.6	28.9	30.2	29.9	30.9	31.2	34.4
State and local	12.5	12.0	12.0	12.3	10.8	9.9	11.0	12.0	14.5	14.5

¹ Estimates prepared by the Congressional Budget Office.

Note: Numbers may not add to totals due to rounding. Percentage amounts are calculated on unrounded numbers.

Source: Health Care Financing Administration, Office of the Actuary; Data from the Office of National Health Statistics.

EXPENDITURES FOR HOSPITAL CARE

In 1991, hospital expenses accounted for 38.4 percent, or \$289 billion, of total national health expenditures, down from 41 percent in 1980.

Table C-6 displays historical trends on increases in hospital costs from 1965 to the present, focusing specifically on community hospital expenditures. Community hospitals are defined as all non-Federal short-term general hospitals (excluding, after 1971, hospital units of institutions) and account for 85 percent of hospital spending. Four measures are presented (total expenses, adjusted expenses per inpatient day, adjusted expenses per admission, and inpatient expenses). Total expenses have been growing slightly faster than inpatient expenses over time, reflecting tremendous growth in outpatient services and decreasing admissions and length of stay.

The total expenses of community hospitals, including inpatient and outpatient expenses, were \$278.9 billion in 1993, an increase of 6.9 percent over the preceding year. The average cost of a day of hospital care (adjusted to include outpatient care) increased by 8.1 percent to \$1,002 in 1993. The average cost per hospital admission (also adjusted to include outpatient care), or "cost per case," rose to \$6,226 in 1993, an increase of 5.4 percent. These were the lowest rates of growth in almost a decade for all of these measures.

Figure 1 presents the annual percentage increases in expenses per adjusted admission, removing the effects of inflation. As of October 1993, the real rate of growth in expenses per adjusted admission was the slowest since 1980.

TABLE C-6.—SELECTED COMMUNITY HOSPITAL EXPENSES DATA, TOTALS AND PERCENTAGE INCREASES, 1965-93

Year	Total expenses		Adjusted ex- penses per inpa- tient day ¹		Adjusted ex- penses per ad- mission		Inpatient ex- penses ²	
	Amount (bil- lions)	Per- cent change	Amount	Per- cent change	Amount	Per- cent change	Amount (bil- lions)	Per- cent change
1965	\$9.220	8.6	\$41	7.5	\$315	8.1	\$8.414	8.7
1966	10.497	13.8	46	12.2	356	13.0	9.611	14.2
1967	12.624	20.3	53	15.2	425	19.4	11.551	20.2
1968	14.720	16.6	59	11.3	482	13.4	13.371	15.8
1969	17.247	17.2	68	15.2	551	14.3	15.635	16.9
1970	20.261	17.5	78	14.7	608	10.3	18.328	17.2
1971	22.496	11.0	87	11.5	670	10.2	20.269	10.6
1972	25.223	12.1	96	10.3	729	8.8	22.622	11.6
1973	28.248	12.0	105	9.4	784	7.5	25.173	11.3
1974	32.759	16.0	118	12.4	873	11.4	29.077	15.5
1975	38.492	17.5	138	16.9	1,017	16.5	33.971	16.8
1976	45.842	19.1	158	14.5	1,168	14.8	40.321	18.7
1977	53.006	15.6	181	14.5	1,312	12.3	46.437	15.2
1978	59.802	12.8	203	12.2	1,466	11.7	52.131	12.3
1979	67.833	13.4	226	11.3	1,618	10.4	59.060	13.3
1980	79.340	17.0	256	13.3	1,836	13.5	68.962	16.8
1981	94.187	18.7	299	16.8	2,155	17.4	81.651	18.4
1982	109.091	15.8	348	16.4	2,489	15.5	94.346	15.5
1983	120.220	10.2	391	12.5	2,742	10.2	103.403	9.5
1984	126.028	4.6	443	13.3	2,947	7.5	107.000	3.2
1985	134.043	6.6	493	11.2	3,226	9.4	111.402	4.4
1986	146.032	8.9	535	8.6	3,527	9.3	119.281	7.1
1987	161.322	10.5	581	8.6	3,860	9.5	129.300	8.4
1988	177.770	10.2	632	8.8	4,194	8.6	140.482	8.2
1989	195.377	9.9	690	9.3	4,586	9.3	152.147	8.3
1990	217.113	11.1	765	10.7	5,021	9.5	165.792	9.0
1991	238.633	9.9	844	10.3	5,460	8.8	178.401	7.6
1992	260.994	9.4	927	9.8	5,905	8.1	191.401	7.3
1993 ³	278.928	6.9	1,002	8.1	6,226	5.4	202.179	5.6

¹ Adjusted to account for the volume of outpatient visits.² Based on ratio of inpatient to total patient revenues applied to total expenses.³ Estimate based on January through October 1993 compared with January through October 1992.

Source: American Hospital Association, National Hospital Panel Survey.

A variety of factors other than overall inflation contribute to aggregate changes in hospital expenses, including: population growth, aging of the population, inflation over and above general inflation in the prices of goods and services purchased by the hospitals (input factor prices), and changes in the type and mix (intensity) of services rendered (due to such factors as changes in the use of technology or treatment patterns). While more than half of the overall growth in inpatient hospital expenditures between 1980 and 1990 was due to overall inflation, more than 10 percent was attributable to population growth, and one-fifth to excess inflation in hospital prices (see Figure C-2). The remainder was due to changes in utilization and intensity.

Expenditures for hospital care are financed primarily by third parties (see Table C-7). In 1991, private health insurers paid 35.2

percent of the total, Medicare and Medicaid paid 33.7 percent, and other government programs paid 15.9 percent. The amount financed out-of-pocket by consumers was an estimated 3.4 percent.

Table C-7 also shows that the Medicare share of spending dropped steadily from 1985 to 1989, the first such decreases since the early 1970s. HCFA attributed this decline to the relatively slow growth in Medicare payments per hospital admission.

TRENDS IN HOSPITAL UTILIZATION

Admissions

From 1978 to 1983, total admissions increased at an annual rate of 1.1 percent, and admissions for persons age 65 and over increased an average of 4.8 percent per year (see Table C-8). With the introduction of Medicare's prospective payment system (PPS), admissions of patients 65 and older declined sharply, contrary to most expectations. Admissions of younger patients, however, had been decreasing for several years before that. Between 1987 and 1992, total admissions continued to decrease, but at a slower rate, due to an increase among the older population. 1993 was the first time in 12 years that overall admissions increased due to a slower rate of decline among the under 65 population and an increase for the over 65 population. Even for the older group, however, admission rates have not returned to pre-PPS levels.

Average length of stay

Before the implementation of PPS, average length of stay (LOS) for all adults was relatively constant at between 7.0 and 7.2 days (see Table C-9). With the introduction of PPS, there was a significant drop in LOS. From 1982 to 1984, LOS dropped by 6.9 percent, to 6.6 days, for all adults and 10.9 percent, to 5.8 days, for adults age 65 and over in 1985. LOS stabilized at these levels throughout the rest of the 1980s. LOS began to decline again in 1990, and, as of 1993, had declined by 6 percent for all adults and 8 percent for adults aged 65 and over, to 5.2 and 5.0 days respectively.

Hospital occupancy

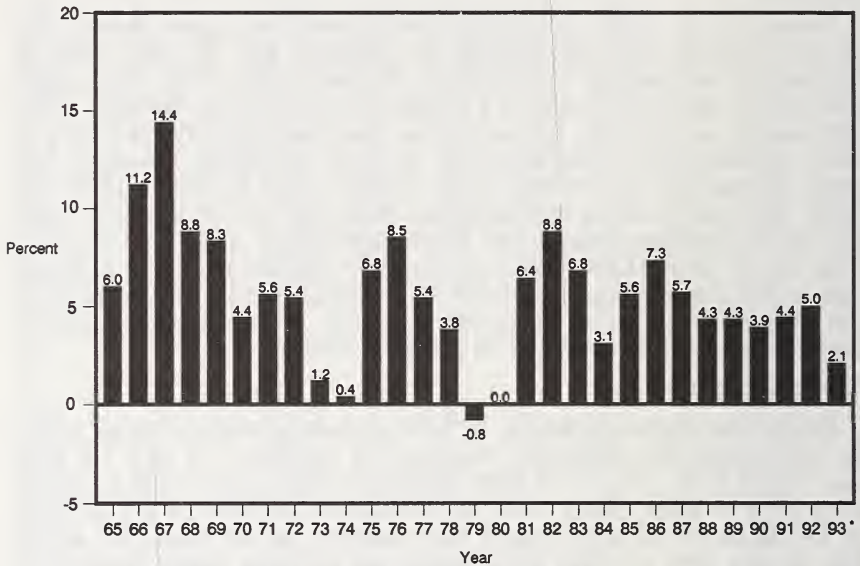
With slight increases in admissions and stable LOS, occupancy rates averaged around 75 percent in the early 1980s (see Table C-11). The number of hospital beds was increasing, exceeding 1 million by 1983. During the early years of PPS, however, occupancy rates decreased dramatically. From 1983 to 1986, the average occupancy rate fell from 72.2 percent to 63.4 percent. There was a slight increase in occupancy rates in the late 1980s, but by 1993 the average occupancy rate had fallen to 61.5 percent, despite a decline in the number of beds to just over 900,000.

Hospital employment

Hospitals experienced a significant downturn in total employment levels at the time PPS was introduced (see Table C-10). During 1984 and 1985, total hospital FTEs declined 2.3 percent. Between 1986 and 1992, however, total hospital employment consistently increased. Much of this growth may be attributed to increased employment in the outpatient area. During the late 1980s,

growth in the number of part-time personnel exceeded growth in the number of full-time personnel in every year. In 1992, the number of full-time personnel grew faster than the number of part-time personnel for the first time in at least 15 years. This trend continued in 1993, but the rate of increase in both types of personnel slowed dramatically, from 1.7 percent to 1.0 percent for full-time personnel and .9 percent to .4 percent for part-time personnel.

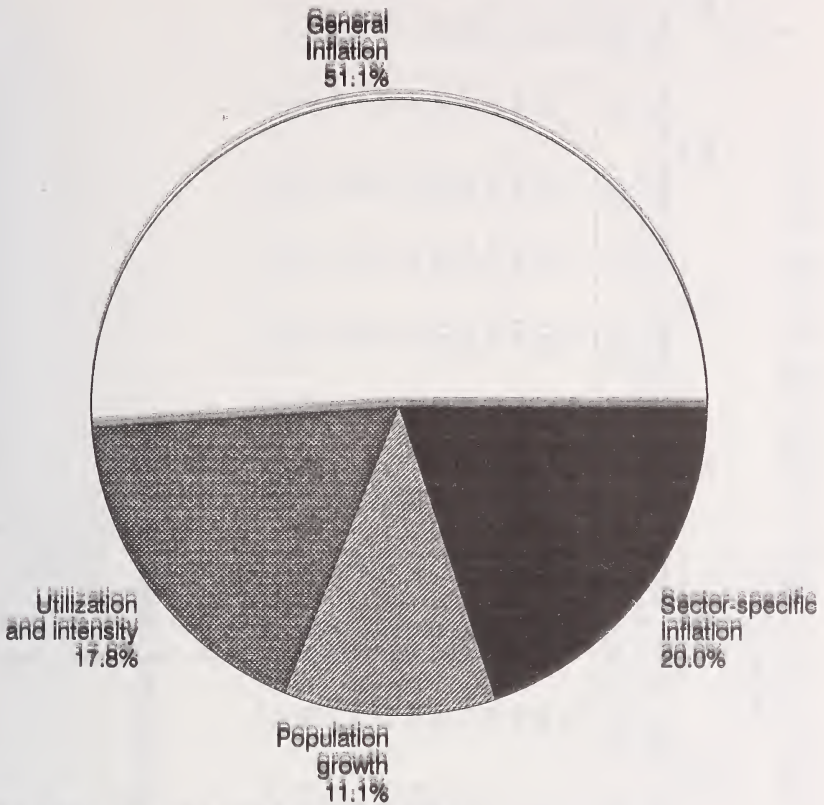
FIGURE C-1.—REAL ANNUAL INCREASES IN EXPENSES PER ADJUSTED ADMISSION (IN PERCENT), 1965-93



* Estimate based on January through October 1993 compared with January through October 1992.

SOURCE: ProPAC analysis of AHA National Hospital Panel Survey data.

FIGURE C-2.—FACTORS ACCOUNTING FOR GROWTH IN NATIONAL INPATIENT HOSPITAL EXPENDITURES, 1980-90



SOURCE: Health Care Financing Administration Office of the Actuary.

TABLE C-7.—EXPENDITURES FOR HOSPITAL CARE, BY SOURCE OF FUNDS, 1980, 1985, 1988, 1989, AND 1988-91
 (Amounts in billions)

Source of payment	1980		1985		1988		1989		1990		1991	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	\$102.4	100.0	\$158.3	100.0	\$212.0	100.0	\$232.4	100.0	\$258.1	100.0	\$288.6	100.0
Out of pocket	5.3	5.2	8.8	5.2	10.4	4.9	10.8	4.7	10.3	4.0	9.9	3.4
Third-party payments	97.1	94.8	159.5	94.8	201.6	95.1	221.6	95.3	247.7	96.0	278.7	96.6
Private health insurance	37.5	36.6	59.6	35.4	76.2	36.0	84.3	36.3	94.3	36.6	101.5	35.2
Other private funds	5.0	4.9	8.3	4.9	11.1	5.3	12.6	5.4	13.9	5.4	14.7	5.1
Government	54.6	53.3	91.6	54.4	114.3	53.9	124.7	53.7	139.5	54.0	162.6	56.3
Federal	41.3	40.4	71.8	42.7	86.2	40.6	94.0	40.4	104.0	40.3	119.1	41.3
Medicare	26.4	25.8	48.6	28.9	57.5	27.1	62.5	26.9	67.4	26.1	73.3	25.4
Medicaid ¹	5.3	5.2	8.4	5.0	11.2	5.3	13.0	5.6	16.3	6.3	23.9	8.3
Other Federal programs	9.7	9.4	14.8	8.8	17.5	8.3	18.5	8.0	20.3	7.8	21.9	7.6
State and local	13.3	12.9	19.7	11.7	28.1	13.2	30.7	13.2	35.5	13.7	43.5	15.1
Medicaid ²	4.4	4.3	7.1	4.2	8.8	4.2	9.9	4.3	12.6	4.9	19.4	6.7
Other State and local programs	8.9	8.7	12.7	7.5	19.3	9.1	20.8	8.9	22.9	8.9	24.0	8.3

¹ Federal share only.

² State and local share only.

Note.—Numbers may not add to totals because of rounding.

Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

TABLE C-8.—PERCENT CHANGE IN HOSPITAL ADMISSIONS, 1978-93

Year	Admissions		
	All	Under age 65	Age 65 and over
1978	0.4	-1.0	4.9
1979	2.7	1.7	5.3
1980	2.9	1.5	6.7
1981 .....	.9	0.0	3.0
1982	0.0	-1.6	4.1
1983	-.5	-2.8	4.7
1984	-3.7	-4.2	-2.6
1985	-4.9	-4.7	-5.2
1986	-2.1	-2.5	-1.0
1987	-.6	-1.0	.4
1988	-.4	-1.6	2.0
1989	-1.1	-2.0	1.2
1990	-.5	-1.6	1.7
1991	-1.1	-2.9	2.5
1992	-0.8	-2.2	1.7
1993 ¹	0.2	-1.0	2.2
Average annual change:			
1978-83	1.1	-.4	4.8
1984-93	-1.5	-2.4	0.3

¹ Estimate based on January through October 1993 compared with January through October 1992.

Source: American Hospital Association National Hospital Panel Survey.

TABLE C-9.—CHANGE IN AVERAGE LENGTH OF STAY, ALL ADULTS AND ADULTS AGE 65 AND OVER, 1978-93

Year	All adults length of stay (days)	Percent change	Age 65 and over (days)	Percent change
1978	7.2	-0.3	10.6	-1.2
1979	7.1	-1.1	10.4	-1.9
1980	7.2	.6	10.4	-.1
1981	7.2	.4	10.4	-.1
1982	7.2	-.7	10.1	-2.3
1983	7.0	-2.0	9.7	-4.4
1984	6.7	-5.1	9.0	-7.5
1985	6.6	-1.7	8.8	-2.1
1986	6.6	.6	8.8	.4
1987	6.6	.8	8.9	1.0
1988	6.6	0.0	8.8	-.7
1989	6.6	0.0	8.8	0.0
1990	6.6	0.0	8.7	-1.1
1991	6.5	-1.5	8.5	-2.3
1992	6.4	-1.5	8.3	-2.4
1993 ¹	6.2	-3.1	8.0	-3.6
Average annual change:				
1978-83 .....	.....	-.5	.....	-1.7
1984-93 .....	.....	-1.2	.....	-1.9

¹ Estimate based on January through October 1993 compared with January through October 1992.

Source: American Hospital Association National Hospital Panel Survey.

TABLE C-10.—PERCENT CHANGE IN HOSPITAL EMPLOYMENT, 1978-93

Year	Total hospital FTE's	Personnel		
		Total	Full-time	Part-time
1978	3.7	4.1	3.3	6.8
1979	3.5	3.9	3.0	6.7
1980	4.7	5.2	4.0	9.1
1981	5.4	6.0	4.8	9.4
1982	3.7	3.7	3.6	4.1
1983	1.4	1.5	1.2	2.3
1984	-2.3	-2.1	-2.6	-.8
1985	-2.3	-1.8	-2.7	-.1
1986 .....	.3	.4	.3	.7
1987 .....	.7	.9	.4	2.3
1988	1.1	1.4	.7	3.3
1989	1.6	1.9	1.2	3.6
1990	2.1	2.3	1.8	3.6
1991 .....	.6	.7	.6	1.0
1992	1.6	1.5	1.7	.9
1993 ¹ .....	.9	.8	1.0	.4
Average annual change:				
1978-83	3.7	4.1	3.3	6.4
1984-93 .....	.4	.6	.2	1.5

¹ Estimate based on January through October 1993 compared with January through October 1992.

Source: American Hospital Association National Hospital Panel Survey.

TABLE C-11.—CHANGE IN INPATIENT HOSPITAL OCCUPANCY RATES AND NUMBER OF BEDS, 1978-93

Year	Percent		Number of beds	Percent change
	Occupancy rates	Change		
1978	73.8	- 0.8	954,001	0.9
1979	74.5	.9	959,269	.6
1980	75.9	1.9	970,456	1.2
1981	75.8	-.1	986,917	1.7
1982	74.6	-1.6	997,720	1.1
1983	72.2	-3.2	1,003,658	.6
1984	66.6	-7.8	992,616	-1.1
1985	63.6	-4.5	974,559	-1.8
1986	63.4	-.3	963,133	-1.2
1987	64.1	1.1	954,458	-.9
1988	64.5	.6	942,306	-1.3
1989	65.2	1.1	930,994	-1.2
1990	64.5	-1.1	921,447	-1.0
1991	63.5	-1.6	911,781	-1.0
1992	62.4	-1.7	907,661	-.5
1993 ¹	61.5	-1.4	901,985	- .6
Annual average:				
1978-83		-.5		1.0
1984-92		-1.6		-1.0

¹ Estimate based on January through October 1993.

Source: American Hospital Association National Hospital Panel Survey.

EXPENDITURES FOR PHYSICIANS' SERVICES

Personal health care expenditures for physicians' services were \$142.0 billion in 1991, an increase of 10.2 percent from the previous year (see table 12). In 1991, 18.9 percent of national health expenditures and 21.5 percent of personal health expenditures were for physicians' services (see table C-1). Physicians, however, affect personal health care expenditures more than this might indicate. Physicians have considerable discretion in determining the volume of all medical services. It is estimated that physicians' decisions (such as ordering hospitalizations, drugs, laboratory tests) directly influence over 70 percent of all health care spending.

Third-party (public expenditures and private insurance) payments financed a large majority of physicians' services. In 1991, private health insurance paid \$66.8 billion (47 percent) for such services. The remainder was split between direct patient payments and public expenditures. Patients or their families paid \$25.7 billion (18 percent) for physicians' services. Public programs paid \$49.4 billion (35 percent) for such services, of which \$32.8 billion was Federal Medicare payments (see table C-12).

Inflation was a major cause of growth in spending for physicians' services. Physicians' fees have risen more rapidly (5.6 percent in 1993) than prices in the economy as a whole (3.0 percent) as measured by the Consumer Price Index (CPI) (see table C-13).

An analysis done by the Health Care Financing Administration found that expenditures for physicians' services over a 10-year span increased from \$41.9 billion in 1980 to \$142.0 billion in 1991, an average annual growth rate of 11.7 percent.

The average physician net income in 1991, after expenses but before taxes, was \$170,600, a 6.3 percent increase over the previous year (see table C-14). Surgeons had the highest average net incomes in 1991 (\$233,800) and general and family practitioners the lowest (\$111,500). In 1991, the average net income of pediatricians increased faster than any other specialty (12.0 percent).

By region, average net income growth varied greatly, ranging from -9.3 percent in Mountain region to 9.5 percent in the Middle Atlantic region. Physicians in the East South Central and West South Central regions had the highest average net incomes (\$179,400 and \$193,300 respectively). Physicians in the New England region had the lowest average net incomes (\$143,800). The growth rates differed rather significantly between metropolitan and nonmetropolitan areas, as shown in table C-14. The average net incomes of self-employed physicians (\$191,000) continued to be higher than those of employee physicians (\$134,000).

Table C-15 shows average physician net incomes in nominal and real (or constant) dollars. Real income is expressed in 1991 dollars. Physicians' average net income increased about 182 percent between 1977 and 1991. However, average real incomes increased about 26 percent during this period, at an average annual rate of 1.8 percent.

Table C-16 shows physicians' median net incomes by specialty. Between 1981 and 1991, real net income increased in all specialties. Table C-17 shows the distribution of physicians' net incomes in 1991 for all physicians and selected specialties. While the average net income of all physicians was \$170,600, half of all physicians earned less than \$139,000. One-fourth of all physicians earned less than \$95,000, while one-fourth earned more than \$210,000. Anesthesiologists, radiologists, obstetricians/gynecologists and surgeons had the highest median incomes, with half earning \$200,000 or more.

The continuing survey of physicians' incomes conducted by the magazine Medical Economics showed that, on average, physicians received 83 percent of their 1992 gross practice incomes from third parties (see table C-18). On average, 17 percent came from commercial insurers, 14 percent from Blue Shield, 26 percent from Medicare, 10 percent from health maintenance organizations (HMOs) and independent practice associations (IPAs), and 6 percent from preferred provider organizations (PPOs). As table C-18 indicates, the importance of each source of payment varied by specialty. Cardio/thoracic surgeons received the highest percentage of gross pay from Medicare (50 percent), while pediatricians, on average, received only 1 percent of their gross income from Medicare.

TABLE C-12.—EXPENDITURES FOR PHYSICIAN SERVICES¹ BY SOURCE OF FUNDS, 1980, 1985, AND 1987-91

	1980		1985		1987		1988		1989		1990		1991	
	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent	Amount	Per- cent
Total	\$41.9	100.0	\$74.0	100.0	\$93.0	100	\$105.1	100.0	\$116.1	100.0	\$128.8	100.0	\$142.0	100.0
Out-of-pocket payments	11.3	26.9	16.1	21.8	19.0	20.4	20.9	19.9	22.5	19.4	24.1	18.7	25.7	18.1
Third-party payments	30.6	73.1	57.8	78.2	74.0	79.6	84.3	80.1	93.6	80.6	104.8	81.3	116.3	81.9
Private health insurance	18.0	42.9	33.7	45.6	42.6	45.8	49.1	46.7	53.9	46.4	60.7	47.1	66.8	47.0
Other private funds	(²)	(²)	(²)	(²)	(²)	(²)	(²)	(²)	(²)	(²)	(²)	(²)	(²)	(²)
Government	12.6	30.2	24.1	32.6	31.4	33.8	35.1	33.4	39.6	34.1	44.0	34.2	49.4	34.8
Federal	9.7	23.1	19.2	26.0	25.1	27.0	28.1	26.7	31.7	27.3	34.9	27.1	39.0	27.5
Medicare	7.9	19.0	16.7	22.5	21.7	23.3	24.2	23.0	27.4	23.6	29.7	23.1	32.8	23.1
Medicaid	1.2	2.8	1.6	2.2	2.0	2.2	2.2	2.1	2.5	2.2	3.1	2.4	4.0	2.8
Other Federal programs .....	.5	1.3	1.0	1.3	1.4	1.5	1.7	1.6	1.8	1.5	2.0	1.6	2.2	1.6
State and local	3.0	7.1	4.9	6.6	6.3	6.8	7.0	6.7	7.9	6.8	9.1	7.1	10.4	7.3
Medicaid	1.0	2.3	1.2	1.7	1.5	1.7	1.5	1.5	1.7	1.5	2.1	1.7	2.9	2.0
Other State and local programs	2.0	4.8	3.6	4.9	4.8	5.1	5.5	5.2	6.2	5.3	7.0	5.4	7.5	5.3

¹ Encompasses the cost of all services and supplies provided in physicians' offices, the cost for services of private practitioners in hospitals and other institutions, and the cost of diagnostic work performed in independent clinical laboratories. The salaries of staff physicians are counted with expenditures for the services of the employing institution.

² Less than \$50 million.

Note: Numbers may not add to totals due to rounding.

Source: Health Care Financing Administration: Office of the Actuary: Data from the Office of National Health Statistics.

TABLE C-13.—ANNUAL RATES OF CHANGE IN THE CONSUMER PRICE INDEX (CPI-U),¹
1965-93

	CPI all items	CPI, all items less medical care	Medical care total	Physicians' services
1965	1.6	1.6	2.4	3.6
1966	2.9	3.1	4.4	5.6
1967	3.1	2.1	7.2	7.2
1968	4.2	4.2	6.0	5.6
1969	5.5	5.4	6.7	7.0
1970	5.7	5.9	6.6	7.5
1971	4.4	4.1	6.2	7.0
1972	3.2	3.2	3.3	3.0
1973	6.2	6.4	4.0	3.4
1974	11.0	11.2	9.3	9.2
1975	9.1	9.0	12.0	12.1
1976	5.8	5.3	9.5	11.4
1977	6.5	6.3	9.6	9.1
1978	7.6	7.6	8.4	8.4
1979	11.3	11.5	9.2	9.1
1980	13.5	13.6	11.0	10.5
1981	10.3	10.4	10.7	11.0
1982	6.2	5.9	11.6	9.4
1983	3.2	2.9	8.8	7.8
1984	4.3	4.1	6.2	6.9
1985	3.6	3.4	6.3	5.9
1986	1.9	1.5	7.5	7.2
1987	3.6	3.5	6.6	7.3
1988	4.1	3.9	6.5	7.2
1989	4.8	4.6	7.7	7.4
1990	5.4	5.2	9.0	7.1
1991	4.2	3.9	8.7	6.0
1992	3.0	2.8	7.4	6.3
1993	3.0	2.7	5.9	5.6

¹ CPI index for all urban consumers.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index.

TABLE C-14.—PHYSICIANS' AVERAGE NET INCOME AFTER EXPENSES BUT BEFORE TAXES, SURVEY RESULTS, 1983-91

	Average net income ¹ (in thousands of dollars)									Percent change 1990-91
	1983	1984	1985	1986	1987	1988	1989	1990	1991	
All physicians ²	104.1	108.4	112.2	119.5	132.3	144.7	155.8	164.3	170.6	6.3
Specialty:										
General/family practice	68.5	71.1	77.9	80.3	91.5	94.6	95.9	102.7	111.5	8.6
Internal medicine	93.3	103.2	101.0	109.4	121.8	130.9	146.5	152.5	149.6	-1.9
Surgery	145.5	151.8	155.4	162.4	187.9	207.5	220.5	236.4	233.8	-1.1
Pediatrics	70.7	74.5	77.1	81.8	85.3	94.9	104.7	106.5	119.3	12.0
Obstetrics/gynecology	119.9	116.2	122.7	135.9	163.2	180.7	194.3	207.3	221.8	7.0
Radiology	148.0	139.8	150.8	168.8	180.7	188.5	210.5	219.4	229.8	4.7
Psychiatry	80.0	85.5	88.6	91.5	102.7	111.4	111.7	116.5	127.6	9.5
Anesthesiology	144.7	145.4	140.2	150.2	163.1	194.5	185.8	207.4	221.1	6.6
Census Division:										
New England	84.5	87.3	108.3	107.1	110.6	132.9	128.3	142.5	143.8	.9
Middle Atlantic	98.6	98.4	107.9	114.6	126.1	135.0	152.5	156.1	171.0	9.5
East North Central	114.3	109.4	118.9	126.6	137.6	147.0	155.6	172.4	174.1	1.0
West North Central	110.5	110.7	113.7	120.7	133.9	138.0	159.2	151.4	164.2	8.4
South Atlantic	106.7	114.5	112.6	119.6	133.8	156.0	165.6	169.0	168.8	-1.1
East South Central	114.9	122.2	115.0	122.6	141.2	164.8	173.0	169.0	179.4	6.1
West South Central	124.4	119.1	123.3	129.0	140.4	160.7	170.5	178.8	193.3	8.1
Mountain	91.4	102.3	97.5	108.5	125.5	132.1	142.6	170.9	155.0	-9.3
Pacific	103.1	109.4	113.6	119.0	135.4	136.0	148.1	162.5	172.4	6.1

TABLE C-15.—AVERAGE PHYSICIAN NET INCOME AFTER EXPENSES, BEFORE TAXES,
1977-91

[Dollars in thousands]

	Nominal	Real (1991)
1977	\$60.4	\$135.8
1978	64.6	134.5
1979	77.4	145.2
1980	NA	NA
1981	89.9	134.7
1982	97.7	137.9
1983	104.1	142.4
1984	108.4	142.1
1985	112.2	142.0
1986	119.5	148.5
1987	132.3	158.6
1988	144.7	166.6
1989	155.8	171.1
1990	164.3	171.2
1991	170.6	170.6

NA: Not available.

Note.—No data for 1980. Real (1991 dollars) incomes are calculated using the consumer price index for all urban consumers.

Source: CRS analysis of data from: Gonzales, Martin L., and David W. Emmons, eds., "Socioeconomic Characteristics of Medical Practice, 1993," American Medical Association.

TABLE C-16.—MEDIAN PHYSICIAN NET INCOME AFTER EXPENSES, BEFORE TAXES, 1981 AND 1991

[Dollars in thousands]

	Median net income			Average annual per- cent change	
	1981	1991 nominal	1991 real ¹	Nominal	Real
All physicians ²	\$75	\$139	\$93	6.9	3.3
Specialty:					
General/family practice ..	60	98	65	5.4	0
Internal medicine	72	125	83	4.2	0
Surgery	100	200	133	0	-4.3
Pediatrics	55	105	70	5.0	0
Obstetrics/gynecology	96	200	133	8.7	3.9
Radiology	105	223	149	1.2	7.2
Psychiatry	64	110	73	2.8	-1.4
Anesthesiology	105	210	140	5.0	.7
Pathology	75	153	102	2.0	-1.9
Census Division:					
New England	65	124	83	3.3	0
Middle Atlantic	70	136	91	8.8	4.6
East North Central	80	133	89	-5.0	-8.3
West North Central	80	141	94	8.5	4.4
South Atlantic	77	130	87	-2.0	-5.4
East South Central	80	150	100	7.1	3.1
West South Central	80	150	100	0	-3.9
Mountain	74	137	91	1.5	-3.2
Pacific	77	150	100	11.1	6.4

¹ In 1981 dollars.² Includes physicians in specialties not listed separately.

Source: Gonzalez, Martin L., and David W. Emmons, eds. "Socioeconomic Characteristics of Medical Practice, 1993," American Medical Association.

TABLE C-17.—DISTRIBUTION OF PHYSICIAN NET INCOME AFTER EXPENSES, BEFORE TAXES, BY SPECIALTY AND CENSUS DIVISION, 1991

[In thousands of dollars]

	125th Per- centile	150th Per- centile	175th Per- centile	Mean
All physicians ¹	95	139	210	170.6
Specialty:				
General/family practice	74	98	128	111.5
Internal medicine	90	125	177	149.6
Surgery	133	200	287	223.8
Pediatrics	80	105	145	119.3
Obstetrics/gynecology	124	200	300	221.8
Radiology	150	223	300	229.8
Psychiatry	88	110	159	127.6
Anesthesiology	157	210	275	221.1
Pathology	110	153	230	197.7
Census division:				
New England	90	124	180	143.8
Middle Atlantic	95	136	210	171.0
East North Central	90	133	208	174.1
West North Central	100	141	200	164.2
South Atlantic	90	130	200	168.8
East South Central	98	150	230	179.4
West South Central	100	150	250	193.3
Mountain	97	137	200	155.0
Pacific	93	150	220	172.4

¹ Includes physicians in specialties not listed separately.

Source: Gonzalez, Martin L., and David W. Emmons, eds. "Socioeconomic Characteristics of Medical Practice, 1993." American Medical Association.

TABLE C-18.—THIRD PARTY SOURCES OF PHYSICIAN PAYMENT FOR SELECTED SPECIALTIES, 1992

Specialty	Commercial plans			Blue Shield			Medicare			Medicaid			HMOs/IPAs			PPOs		
	Average annual payment	As percent of gross practice income		Average annual payment	As percent of gross practice income		Average annual payment	As percent of gross practice income		Average annual payment	As percent of gross practice income		Average annual payment	As percent of gross practice income		Average annual payment	As percent of gross practice income	
Cardiologists	\$61,400	15		\$56,100	14		\$177,490	46		\$18,220	5		\$27,530	6		\$16,730	4	
Cardio/thoracic surgeons	61,200	12		70,670	14		241,890	50		31,410	6		44,000	10		17,980	4	
Family practice	33,420	14		30,290	12		54,170	22		25,320	11		27,720	12		18,140	7	
Gastroenterologists	58,600	14		57,500	15		151,640	40		21,620	6		32,140	10		19,810	5	
General practice	30,870	14		23,940	12		45,230	24		20,210	12		23,300	10		15,250	5	
General surgeons	62,430	19		53,810	17		103,590	33		26,100	9		31,890	10		20,510	6	
Pediatricians	36,860	15		33,350	14		810	1		53,800	24		31,890	15		22,830	9	
Plastic surgeons	84,410	20		61,030	14		54,450	13		13,910	4		25,960	6		30,810	7	
Psychiatrists	38,910	20		23,610	13		22,780	11		10,870	6		10,000	5		13,190	6	
Internists	31,060	12		33,700	12		101,320	39		12,380	5		22,230	10		16,290	6	
Neurosurgeons	154,920	26		77,130	14		118,990	22		35,290	7		55,620	10		39,880	7	
OBG specialists	96,590	24		80,930	20		24,290	7		47,860	11		58,280	15		48,860	11	
Orthopedists	122,860	24		78,430	17		95,950	21		28,810	6		43,510	9		38,570	7	
All surgical specialists	83,980	20		66,010	16		105,590	26		32,030	8		41,800	10		30,930	7	
All non-surgical specialists	46,460	15		39,730	14		87,000	28		24,080	10		28,480	10		18,370	6	
All M.D.s	55,600	17		45,710	14		86,070	26		26,390	10		32,150	10		22,030	6	

Source: Terry, Ken, "Where more of your income is coming from," Medical Economics, Nov. 22, 1993.

SUPPLY OF HOSPITAL BEDS

The national supply of community hospital beds per 1,000 population steadily increased from the 1940's, reaching a peak of 4.6 beds per 1,000 population in 1975. By 1989, the number of beds had dropped to 3.8 per 1,000 population, and remained at that level in 1990. Similar trends can be seen in the nine census regions, except for New England, which has seen a reduction since 1940 from 4.4 beds to 3.4 beds per 1,000 population in 1990, and the Pacific region, where the reduction has been from 4.1 beds in 1940 to 2.7 beds in 1990. The area experiencing the largest increase has been the East South Central, where beds increased from 1.7 per 1,000 population in 1940 to 5.1 in 1980, falling back to 4.8 in 1990. (see table C-19).

TABLE C-19.—COMMUNITY HOSPITAL BEDS PER 1,000 POPULATION AND AVERAGE ANNUAL PERCENT CHANGE, ACCORDING TO GEOGRAPHIC DIVISION AND STATE:
UNITED STATES, SELECTED YEARS 1940-90

[Data are based on reporting by facilities]

Geographic division and State	Beds per 1,000 civilian population										Average annual percent change			
	1940 ¹	1950 ¹	1960 ²	1970	1980	1985	1988	1989	1990	1990	1940-60 ^{1,2}	1960-70 ²	1970-80	1980-90
United States	3.2	3.3	3.6	4.3	4.5	4.2	3.9	3.8	3.8	3.8	0.6	1.8	0.5	-1.7
New England	4.4	4.2	3.9	4.1	4.1	4.0	3.6	3.5	3.4	3.4	-0.6	0.5	0.0	-1.9
Maine	3.0	3.2	3.4	4.7	4.7	4.2	3.9	3.8	3.8	3.8	0.6	3.3	0.0	-2.1
New Hampshire	4.2	4.2	4.4	4.0	3.9	3.4	3.2	3.1	3.1	3.1	0.2	-0.9	-0.3	-2.3
Vermont	3.3	4.0	4.5	4.5	4.4	3.8	3.1	3.1	3.1	3.1	1.6	0.0	-0.2	-3.4
Massachusetts	5.1	4.8	4.2	4.4	4.4	4.4	4.0	3.8	3.6	3.6	-1.0	0.5	0.0	-2.0
Rhode Island	3.9	3.8	3.7	4.0	3.8	3.6	3.3	3.2	3.2	3.2	-0.3	0.8	-0.5	-1.7
Connecticut	3.7	3.6	3.4	3.4	3.5	3.3	3.0	3.0	2.9	2.9	-0.4	0.0	0.3	-1.9
Middle Atlantic	3.9	3.8	4.0	4.4	4.6	4.4	4.1	4.1	4.2	4.2	0.1	1.0	0.4	-0.9
New York	4.3	4.1	4.3	4.6	4.5	4.4	4.2	4.2	4.2	4.2	0.0	0.7	-0.2	-0.7
New Jersey	3.5	3.2	3.1	3.6	4.2	3.9	3.7	3.7	3.7	3.7	-0.6	1.5	1.6	-1.3
Pennsylvania	3.5	3.8	4.1	4.7	4.8	4.7	4.4	4.3	4.4	4.4	0.8	1.4	0.2	-0.9
East North Central	3.2	3.2	3.6	4.4	4.7	4.5	4.1	4.0	3.9	3.9	0.6	2.0	0.7	-1.8
Ohio	2.7	2.9	3.4	4.2	4.7	4.6	4.2	4.0	4.0	4.0	1.2	2.1	1.1	-1.6
Indiana	2.3	2.6	3.1	4.0	4.5	4.2	4.1	3.9	3.9	3.9	1.5	2.6	1.2	-1.4
Illinois	3.4	3.6	4.0	4.7	5.1	4.7	4.3	4.1	4.0	4.0	0.8	1.6	0.8	-2.4
Michigan	4.0	3.3	3.3	4.3	4.4	4.1	3.8	3.7	3.7	3.7	-1.0	2.7	0.2	-1.7
Wisconsin	3.4	3.7	4.3	5.2	4.9	4.6	4.0	3.9	3.8	3.8	1.2	1.9	-0.6	-2.5
West North Central	3.1	3.7	4.3	5.7	5.8	5.4	5.1	4.9	4.9	4.9	1.6	2.9	0.2	-1.7
Minnesota	3.9	4.4	4.8	6.1	5.7	5.2	4.8	4.5	4.4	4.4	1.0	2.4	-0.7	-2.6
Iowa	2.7	3.2	3.9	5.6	5.7	5.2	5.2	5.0	5.1	5.1	1.9	3.7	0.2	-1.1
Missouri	2.9	3.3	3.9	5.1	5.7	5.2	4.9	4.8	4.8	4.8	1.5	2.7	1.1	-1.7
North Dakota	3.5	4.3	5.2	6.8	7.4	7.4	7.0	7.0	7.0	7.0	2.0	2.7	0.8	-0.6
South Dakota	2.8	4.4	4.5	5.6	5.5	6.6	5.8	5.5	6.1	6.1	2.4	2.2	-0.2	1.0
Nebraska	3.4	4.2	4.4	6.2	6.0	6.0	5.8	5.5	5.4	5.4	1.3	3.5	-0.3	-1.0
Kansas	2.8	3.4	4.2	5.4	5.8	5.2	4.7	4.8	4.8	4.8	2.0	2.5	0.7	-1.9
South Atlantic	2.5	2.8	3.3	4.0	4.5	4.1	3.8	3.7	3.7	3.7	1.4	1.9	1.2	-1.9
Delaware	4.4	3.9	3.7	3.7	3.6	3.5	3.1	3.0	3.0	3.0	-0.9	0.0	-0.3	-1.8
Maryland	3.9	3.6	3.3	3.1	3.6	3.4	2.9	2.9	2.9	2.9	-0.8	-0.6	1.5	-2.1
District of Columbia	5.5	5.5	5.9	7.4	7.3	7.8	7.8	7.9	7.5	7.5	0.4	2.3	-0.1	0.3
Virginia	2.2	2.5	3.0	3.7	4.1	3.8	3.5	3.4	3.3	3.3	1.6	2.1	1.0	-2.1
West Virginia	2.7	3.1	4.1	5.4	5.5	5.1	4.7	4.7	4.7	4.7	2.1	2.8	0.2	-1.6
North Carolina	2.2	2.6	3.4	3.8	4.2	3.7	3.4	3.4	3.4	3.4	2.2	1.1	1.0	-2.1
South Carolina	1.8	2.4	2.9	3.7	3.9	3.6	3.3	3.2	3.3	3.3	2.4	2.5	0.5	-1.7

TABLE C-19.—COMMUNITY HOSPITAL BEDS PER 1,000 POPULATION AND AVERAGE ANNUAL PERCENT CHANGE, ACCORDING TO GEOGRAPHIC DIVISION AND STATE:
UNITED STATES, SELECTED YEARS 1940-90—Continued

[Data are based on reporting by facilities]

Geographic division and State	Beds per 1,000 civilian population									Average annual percent change			
	1940 ¹	1950 ¹	1960 ²	1970	1980	1985	1988	1989	1990	1940-60 ^{1,2}	1960-70 ²	1970-80	1980-90
Georgia	1.7	2.0	2.8	3.8	4.6	4.3	4.1	4.1	4.0	2.5	3.1	1.9	-1.4
Florida	2.8	2.9	3.1	4.4	5.1	4.6	4.2	4.0	4.0	0.5	3.6	1.5	-2.4
East South Central	1.7	2.1	3.0	4.4	5.1	5.0	4.7	4.7	4.8	2.9	3.9	1.5	-0.6
Kentucky	1.8	2.2	3.0	4.0	4.5	4.4	4.3	4.3	4.4	2.6	2.9	1.2	-0.2
Tennessee	1.9	2.3	3.4	4.7	5.5	5.3	4.8	4.8	4.9	3.0	3.3	1.6	-1.1
Alabama	1.5	2.0	2.8	4.3	5.1	5.0	4.6	4.6	4.6	3.2	4.4	1.7	-1.0
Mississippi	1.4	1.7	2.9	4.4	5.3	5.2	5.4	5.2	5.3	3.7	4.3	1.9	0.0
West South Central	2.1	2.7	3.3	4.3	4.7	4.2	3.9	3.8	3.9	2.3	2.7	0.9	-1.8
Arkansas	1.4	1.6	2.9	4.2	5.0	4.8	4.5	4.5	4.7	3.7	3.8	1.8	-0.6
Louisiana	3.1	3.8	3.9	4.2	4.8	4.6	4.4	4.4	4.6	1.2	0.7	1.3	-0.4
Oklahoma	1.9	2.5	3.2	4.5	4.6	4.1	4.0	3.9	4.0	2.6	3.5	0.2	-1.4
Oklahoma	1.9	2.5	3.2	4.5	4.6	4.1	4.0	3.9	4.0	2.6	3.5	0.2	-1.4
Texas	2.0	2.7	3.3	4.3	4.7	4.1	3.7	3.6	3.5	2.5	2.7	0.9	-2.9
Mountain	3.6	3.8	3.5	4.3	3.8	3.5	3.3	3.1	3.1	-0.1	2.1	-1.2	-2.0
Montana	4.9	5.3	5.1	5.8	5.9	5.5	5.6	5.7	5.8	0.2	1.3	0.2	-0.2
Idaho	2.6	3.4	3.2	4.0	3.7	3.5	3.2	3.2	3.2	1.0	2.3	-0.8	-1.4
Wyoming	3.5	3.9	4.6	5.5	3.6	4.3	4.8	4.7	4.9	1.4	1.8	-4.1	3.1
Colorado	3.9	4.2	3.8	4.6	4.2	3.6	3.3	3.0	3.2	-0.1	1.9	-0.9	-2.7
New Mexico	2.7	2.2	2.9	3.5	3.1	2.9	2.8	2.9	2.9	0.4	1.9	-1.2	-0.7
Arizona	3.4	4.0	3.0	4.1	3.6	3.2	2.9	2.8	2.7	-0.6	3.2	-1.3	-2.8
Utah	3.2	2.9	2.8	3.6	3.1	2.7	2.7	2.6	2.6	0.7	2.5	-1.5	-1.7
Nevada	5.0	4.4	3.9	4.2	4.2	3.7	3.2	3.0	2.9	-1.2	0.7	0.0	-3.6
Pacific	4.1	3.2	3.1	3.7	3.5	3.2	2.9	2.8	2.7	-1.4	1.8	-0.6	-2.6
Washington	3.4	3.6	3.3	3.5	3.1	3.0	2.7	2.6	2.5	-0.1	0.6	-1.2	-2.1
Oregon	3.5	3.1	3.5	4.0	3.5	3.2	2.9	2.9	2.9	0.0	1.3	-1.3	-1.9
California	4.4	3.3	3.0	3.8	3.6	3.2	2.9	2.9	2.7	-1.9	2.4	-0.5	-2.8
Alaska .....	.....	.....	2.4	2.3	2.7	2.2	2.4	2.5	2.3	.....	-0.4	1.6	-1.6
Hawaii .....	.....	.....	3.7	3.4	3.1	2.8	2.7	2.7	2.8	.....	-0.8	-0.9	-1.0

¹ 1940 and 1950 data are estimated based on published figures.² 1960 includes hospital units of institutions.

Sources: American Medical Association: Hospital service in the United States. JAMA 116(11):1055-1144, 1941, and 146(2):109-184, 1951. (Copyright 1941 and 1951: Used with the Permission of the American Medical Association); American Hospital Association: Hospitals. JAMA 35(15):383-430, Aug. 1, 1961. (Copyright 1961: Used with the permission of the American Hospital Association.); Data computed by the Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Analysis from data compiled by the Division of Health Care Statistics, National Master Facility Inventory and the American Hospital Association 1990 annual survey, U.S. Bureau of the Census; Current Population Reports. Series P-25, Nos. 72, 304, 460, 640, 970, 1010, 1044, and 1058. Washington. U.S. Government Printing Office. 1953, 1965, 1971, 1976, 1980, 1985, 1989, and 1990; Health, United States, 1991; DHHS Pub. No. (PHS) 93-1232.

SUPPLY OF PHYSICIANS

Physician supply has grown rapidly over the past three decades. The number of active physicians in the country has increased from 334,028 in 1970 to 653,062 in 1992. This growth rate exceeded the rate at which the population of the Nation grew during the decade.

Table C-20 indicates that between 1965 and 1992, the number of physicians per 100,000 civilians grew from 161 to 255. As table C-21 below indicates, the ratio of nonfederal physicians-to-population increased from 148 physicians per 100,000 population in 1970 to 248 physicians per 100,000 population in 1992. This table also indicates variations in the supply of physicians relative to population by State. In 1992, the District of Columbia had the highest ratio (705 physicians per 100,000 population) while Alaska had the lowest ratio (146 physicians per 100,000 population).

TABLE C-20.—PHYSICIAN SUPPLY BY MAJOR CATEGORIES, 1970-92

Category	1970		1980		1990		1992	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Physicians	334,028	.....	467,679	.....	615,421	.....	653,062	.....
Federal	29,501	9	17,787	4	20,475	3	19,216	3
Nonfederal	301,323	91	443,502	96	592,166	97	631,137	97
Patient Care	278,535	83	376,512	80	503,870	82	535,220	82
Nonpatient Care	32,310	10	38,404	9	43,440	8	42,888	7
Male	308,627	92	413,395	88	511,227	83	534,543	82
Female	25,401	8	54,284	12	104,194	17	118,519	18
International medical graduates	57,217	17	97,726	21	131,764	21	144,399	22
Metropolitan (nonfederal only)	258,265	86	385,365	87	521,668	88	557,900	88
Nonmetropolitan (nonfederal only)	43,058	14	58,137	13	70,498	12	73,237	12
Total physician-population ratio (per 100,000 persons) ...	161	.....	202	.....	244	.....	255	.....

Source: American Medical Association, 1993.

TABLE C-21.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilian population]

State	1970	1975	1985	1990	1992	1992 rank
United States ¹	148	169	220	237	248	
Alabama	90	103	152	170	183	40
Alaska	74	95	137	155	146	51
Arizona	144	185	220	233	233	20
Arkansas	92	103	150	165	179	33
California	194	219	266	272	273	11
Colorado	178	186	216	232	245	16
Connecticut	192	224	302	332	346	5
Delaware	134	155	203	217	228	21
District of Columbia	390	467	607	658	705	1
Florida	155	185	236	251	257	12
Georgia	108	126	172	187	196	35
Hawaii	160	185	239	266	283	9
Idaho	94	104	133	142	150	49
Illinois	138	164	217	229	247	15
Indiana	102	116	156	171	181	41
Iowa	103	113	149	167	175	44
Kansas	118	137	179	195	203	32
Kentucky	102	122	162	181	195	37
Louisiana	120	131	187	200	215	29
Maine	111	133	193	208	218	26
Maryland	183	217	334	360	374	3
Massachusetts	207	237	331	364	380	2
Michigan	125	145	190	201	212	30
Minnesota	151	172	223	240	255	13
Mississippi	84	94	126	144	149	50
Missouri	129	148	195	209	223	24
Montana	104	116	155	181	192	39
Nebraska	116	134	170	185	202	33
Nevada	114	129	173	175	166	47
New Hampshire	140	162	207	227	238	18
New Jersey	146	174	243	267	284	8
New Mexico	113	130	184	206	218	26
New York	236	258	318	339	360	4
North Carolina	111	132	185	209	221	25
North Dakota	96	106	168	184	202	33
Ohio	133	147	199	213	226	23
Oklahoma	103	113	149	160	168	46
Oregon	144	171	215	233	243	17
Pennsylvania	152	169	234	256	275	10
Rhode Island	160	194	248	277	294	7

TABLE C-21.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE—
Continued

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilian population]

State	1970	1975	1985	1990	1992	1992 rank
South Carolina	93	114	161	177	181	41
South Dakota	81	90	143	154	170	45
Tennessee	119	139	189	210	227	22
Texas	117	135	174	188	196	35
Utah	138	155	185	200	208	31
Vermont	187	207	268	288	301	6
Virginia	125	149	214	233	238	18
Washington	149	168	223	241	251	14
West Virginia	104	124	171	183	195	37
Wisconsin	120	137	188	207	216	28
Wyoming	101	108	140	156	158	48

¹Excludes counts of physicians in U.S. possessions and with unknown addresses.

Source: American Medical Association, Physician Characteristics and Distribution in the U.S. 1993 edition. Table A-20.

The number of physicians in the United States is expected to continue to grow at a faster rate than the general population. According to the American Medical Association, there were 248 non-federal physicians per 100,000 population in 1992. The Department of Health and Human Services projects ratios of 271 in 2000 and 298 in 2020.

In 1992, about 35 percent of physicians were in primary care specialties, defined as general and family practice, internal medicine, and pediatrics.

Currently, there are approximately 88,620 residents in training. Growth in the number of residencies over the past twenty years reflects both steep increases in the number of first-year positions during the late 1970s and the increased length of training in many specialties. The number of U.S. medical school graduates, which rose rapidly in the late 1960s and early 1970s, has been relatively stable over the past decade (see table C-23).

Since the late 1970s, efforts to restrict the flow of international medical graduates (IMGs) have included stricter immigration laws and more rigorous competency requirements. As a result, table C-24 shows that IMGs dropped from over 40 percent of all residents in 1971 to about 17 percent in 1985. Since then, the percentage of IMGs has risen to 22 percent.

TABLE C-22.—PHYSICIAN SUPPLY FOR SELECTED SPECIALTIES, 1980–92

Specialty	Federal and non-federal physicians					
	1980		1985		1992	
	Total	Office based	Total	Office based	Total	Office based
Total physicians	467,679	272,000	552,716	330,197	653,062	389,364
Anesthesiology	15,958	11,338	22,021	15,300	28,148	19,998
Cardiovascular diseases	9,823	6,729	13,224	9,063	16,478	11,460
Dermatology	5,660	4,378	6,582	5,333	7,912	6,318
Diagnostic radiology	7,048	4,191	12,887	7,749	17,253	10,900
Emergency medicine .....	.....	.....	11,283	7,295	15,470	9,373
Family practice	27,530	18,378	40,021	29,694	50,969	40,479
Gastroenterology	4,046	2,737	5,917	4,136	7,946	5,724
General practice	32,519	29,642	27,030	24,579	20,719	18,575
General surgery	34,034	22,426	38,169	24,762	39,211	24,956
Internal medicine	71,531	40,617	90,417	52,891	109,017	65,312
Neurology	5,685	3,253	7,776	4,700	9,742	6,330
Neurological Surgery	3,341	2,468	4,019	2,880	4,501	3,310
Obstetrics/gynecology	26,305	19,513	30,867	23,543	35,273	27,115
Ophthalmology	12,974	10,603	14,881	12,221	16,433	13,742
Orthopedic surgery	13,996	10,728	17,166	13,045	20,640	15,832
Otolaryngology	6,553	5,266	7,267	5,755	8,373	6,646
Pathology ¹	13,642	6,081	15,767	7,054	17,428	8,155
Pediatrics ²	29,462	18,210	36,839	23,211	45,921	29,668
Plastic Surgery	2,980	2,438	3,951	3,301	4,688	4,044
Psychiatry ³	30,752	17,965	36,038	20,887	41,023	24,811
Pulmonary diseases	3,715	2,048	5,083	3,038	6,337	4,009
Radiology	11,653	7,802	10,109	7,363	7,848	5,854
Urological surgery	7,743	6,228	8,836	7,089	9,452	7,688
Other surgical specialties ⁴	2,852	2,261	3,000	2,434	2,989	2,394
Other remaining specialties ⁵	22,825	11,741	19,740	9,498	26,228	13,805
Unspecified	12,289	4,959	8,250	3,376	8,109	2,866
Other categories ⁶	52,763	.....	55,576	.....	74,954	.....

Note: Data for 1992 are as of January 1. Data for 1985 and before are as of December 31.

¹ Includes pathology and forensic pathology.

² Includes pediatrics and pediatric cardiology.

³ Includes psychiatry and child psychiatry.

⁴ Includes colon and rectal surgery and thoracic surgery.

⁵ Includes aerospace medicine, allergy/immunology, general preventive medicine, nuclear medicine, occupational medicine, physical medicine and rehabilitation, public health, radiation oncology, and other.

⁶ Includes not classified, inactive, and address unknown: these categories are included in total physicians only, not in office-based physicians.

Source: AMA Physician Masterfile for 1980, 1985, and 1992.

TABLE C-23.—MEDICAL SCHOOL GRADUATES, FIRST-YEAR RESIDENTS AND TOTAL RESIDENTS, 1965-92

Year	Medical school graduates	First-year residents	Total residents
1965	7,409	9,670	31,898
1966	7,574	10,316	31,898
1967	7,743	10,419	33,743
1968	7,973	10,464	35,047
1969	8,059	10,808	37,139
1970	8,367	11,552	39,463
1971	8,974	12,066	42,512
1972	9,551	11,500	45,081
1973	10,391	11,031	49,082
1974	11,613	11,628	52,685
1975	12,714	13,200	54,500
1976	(¹)	14,258	56,872
1977	13,607	15,900	59,000
1978	14,393	16,800	63,163
1979	14,966	17,600	64,615
1980	15,135	18,702	61,465
1981	15,667	18,389	69,738
1982	15,985	18,976	69,142
1983	15,824	18,794	73,000
1984	16,327	19,539	75,125
1985	16,319	19,168	75,514
1986	16,125	18,183	76,815
1987	15,836	18,067	81,410
1988	15,887	17,941	81,093
1989	15,620	18,131	82,000
1990	15,336	18,322	82,902
1991	15,481	19,497	86,217
1992	15,386	19,794	88,620

¹ Not available.

Source: JAMA Medical Education issues.

TABLE C-24.—INTERNATIONAL GRADUATE MEDICAL RESIDENTS BY LOCATION OF EDUCATION AND CITIZENSHIP, 1971-92

	Total	Percent of all residents	U.S. citizens	Foreign nationals
1971	17,515	41	1,063	16,452
1976	16,634	29	1,783	14,851
1981	11,596	17	2,908	8,688
1983	14,084	19	4,961	9,123
1985	12,509	17	6,868	5,609
1991	17,017	20	5,107	11,910
1992	19,084	22	5,015	¹ 14,069

¹ Includes 6,192 permanent resident aliens.

Source: American Medical Association 1986 and JAMA Medical Education issues.

HEALTH INSURANCE COVERAGE

HEALTH INSURANCE STATUS IN 1992

Most people have some form of health insurance. In 1992, an estimated 85.4 percent of the total noninstitutionalized population had public or private coverage during at least part of the year. However, an estimated 37.3 million Americans, or 14.7 percent of the population, were without health insurance in 1992. All but 0.35 million of the uninsured were under age 65; consequently 16.6 percent of the nonelderly population were uninsured.

These estimates are based on an analysis of the March 1993 Current Population Survey (CPS), a household survey conducted by the Census Bureau of the Department of Commerce. Each year's March CPS asks whether individuals had coverage from selected sources of health insurance at any time during the preceding calendar year. Thus the March 1993 CPS reflects respondents' recollections of coverage during all of 1992.²

The questionnaires used in March 1988-93 differed from those used in previous years. In addition to the standard series of questions about sources of health insurance coverage, a separate part of the survey included further health insurance questions. Some respondents reported that they had no health insurance in one part of the questionnaire and reported that they had coverage in another part. Different analyses of the CPS data have used different assumptions in reconciling these discrepancies and other potential sources of error in the survey responses. Also, the March 1988-93 surveys included responses from population groups not surveyed in earlier surveys, including retirees and other nonworking individuals.

CHARACTERISTICS OF THE UNINSURED

Some segments of the population are more likely to have health insurance coverage than others, and different groups rely to a different extent on private insurance coverage and on public programs such as Medicare and Medicaid. Tables C-25 to C-27 divide the population according to age and income and show the sources of coverage for each group.³ (The total noninstitutionalized population in 1992 was 253.9 million.)

² Some analysts have suggested that respondents may actually be reporting their coverage status at the time of the survey, rather than for the previous year.

³ About 13 percent of the population reported more than one source of coverage during the year. The dual coverages many have been either at different points during the year or simultaneous. For the purpose of these tables, CRS has assigned each individual to one primary source of coverage according to the "coordination of benefits" rules typically used by private sector insurance companies.

TABLE C-25.—PERCENT OF U.S. NONINSTITUTIONALIZED POPULATION OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY AGE, 1992

	Own job	Family mem- ber's job	Medicare	Medicaid	Other ¹	Uninsured
Age:						
Under 18	0.1	60.9	0.1	17.4	9.3	12.37
18 to 24	20.9	23.4	0.6	8.7	17.3	28.9
25 to 34	48.2	15.4	1.2	7.1	7.2	20.9
35 to 44	50.5	20.2	1.5	4.2	8.2	15.5
45 to 54	50.8	20.0	2.1	3.3	9.9	14.0
55 to 64	45.2	18.9	5.6	3.4	14.0	12.9
65 and over	4.4	9.0	84.8	0.1	0.5	1.2
Total	28.0	29.0	11.5	8.0	8.9	14.7

¹ "Other" includes, for example, privately purchased health insurance and Department of Veterans Affairs health care services.

Source: CRS analysis of data from the March 1993 Current Population Survey.

As table C-25 shows, the rate of insurance coverage is lowest among young adults; 28.9 percent of persons aged 18 to 24 were without coverage in 1992. Over the next several age groups, coverage rates increase, chiefly because older workers are more likely to obtain insurance through their own employment. Finally, the availability of Medicare to most individuals aged 65 and over meant that about 1 percent of this group was uninsured.

Table C-26 shows the percentage of the total uninsured population of each age group. Of the 37.3 million uninsured, 22.1 percent are children. Young adults (ages 18 to 24) total 18.8 percent and persons 25 to 34 total 23.4 percent of the uninsured.

TABLE C-26.—PERCENT OF U.S. NONINSTITUTIONALIZED POPULATION WITHOUT HEALTH INSURANCE, BY AGE, 1992

Age	Percent of the uninsured
Under 18	22.1
18 to 24	18.8
25 to 34	23.4
35 to 44	16.7
45 to 54	10.7
55 to 64	7.3
65 and over .....	.95
Total	100.0

Note.—Items do not sum to 100.0 due to rounding.

Source: CRS analysis of data from the March 1993 Current Population Survey.

Table C-27 shows coverage rates by family income, expressed as a percentage of the Federal poverty income level. Those in the lowest income groups are least likely to have coverage. If they have coverage, the source is most likely to be Medicaid. As family in-

come rises, both overall coverage rates and the degree of reliance on employer coverage increase.

TABLE C-27.—PERCENT OF U.S. NONINSTITUTIONALIZED POPULATION OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY FAMILY INCOME, 1992

Income as percent of poverty	Own job	Family mem- ber's job	Medicare	Medicaid	Other ¹	Unin- sured
Under 50	2.3	4.0	6.1	49.2	8.7	29.6
50 to 99	5.3	8.6	17.7	32.2	8.4	27.8
100 to 133	10.5	17.1	21.3	13.8	9.5	27.8
134 to 185	16.7	24.5	18.6	6.7	9.3	24.3
185 to 249	24.0	33.1	14.8	2.5	9.0	16.7
250 and over	39.2	34.0	8.0	0.7	8.8	7.4
Total	28.0	28.9	11.5	7.9	8.9	14.7

¹ "Other" includes for example, privately purchased health insurance and Department of Veterans Affairs health care services.

Note.—Rows may not sum to 100.0 due to rounding.

Source: CRS analysis of data from the March 1993 Current Population Survey.

Table C-28 combines age and income and shows the percent of persons in each age/income group without health insurance. Overall, the trends shown in this table are similar to those in the previous tables: the rate of those without insurance drops with increasing age and income.

TABLE C-28.—PERCENT OF THE U.S. NONINSTITUTIONALIZED POPULATION WITHOUT HEALTH INSURANCE, BY AGE AND INCOME, 1992

Income as a percent of poverty level	Under 18	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 and over
Under 50	17.8	41.1	41.8	46.1	42.0	43.7	8.9
50 to 99	22.1	42.9	38.4	41.2	42.6	30.4	1.8
100 to 133	24.7	42.8	42.7	38.5	41.6	27.4	1.2
134 to 185	20.2	41.1	33.5	33.4	35.0	26.3	0.9
185 to 249	13.0	34.5	23.4	18.7	22.5	14.7	1.0
250 and over	4.5	18.1	11.7	6.9	6.5	6.3	0.7

Source: CRS analysis of data from the March 1993 Current Population Survey.

FACTORS IN EMPLOYMENT-BASED COVERAGE

In the United States, health insurance offered on a job is the single most important source of coverage. Employer plans covered 150.5 million Americans in 1992, or approximately 59.3 percent of the population. If only the nonaged are considered, this figure rises to over two-thirds. Persons covered under employer plans are almost equally divided between those obtaining coverage through their own work (77.0 million) and those obtaining coverage as dependents on another family member's policy (73.6 million).

One important factor in employment-based coverage is the degree of attachment to the labor force. Employers who provide coverage to their full-time workers may not offer that coverage to part-time employees. Workers in seasonal industries, who are employed only part of the year, are also less likely to be covered. Table C-29 shows the workforce attachment of the population without health insurance coverage in 1992. Over one-third of the uninsured, 14.0 million, worked only part time or part of the year, or were dependents of part time or part year workers, while another 16.1 percent had no work force attachment. However, 46.4 percent of the uninsured, approximately 17.3 million persons, were full year, full time workers or the dependents of such workers. All told, 31.4 million uninsured persons had at least some ties to the workforce.

The likelihood that workers will obtain coverage through their jobs is largely tied to two characteristics of employers: the size of the firm and the type of industry. Tables C-30 and C-32 show insurance coverage in 1992 for workers classed according to these two characteristics of their employers. As table C-30 indicates, workers in the smallest firms were least likely to obtain employer-based coverage and most likely to be uninsured.

TABLE C-29.—PERSONS WITHOUT HEALTH INSURANCE COVERAGE, BY ATTACHMENT TO THE WORKFORCE, 1992

[Thousands]

	Workers	Dependents	Total	Percent of uninsured
Nonworker	0	6,003	6,003	16.1
Full year/full time worker ..	9,633	7,708	17,342	46.4
Full year/part time worker .	1,892	813	2,706	7.2
Part year/full time worker ..	5,811	2,403	8,215	22.0
Part year/part time worker	2,529	560	3,090	8.3
Total	19,866	17,489	37,355	100.0

¹ Includes both heads of household and dependents with no workforce attachment.

Note.—Items may not sum to total due to rounding. Full year workers were employed 50 or more weeks during the year. Full time workers worked an average of 35 or more hours per week during the weeks they were employed.

Source: CRS analysis of data from the March 1993 Current Population Survey.

TABLE C-30.—PERCENT OF WORKERS OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY SIZE OF EMPLOYER, 1992

Firm size ¹	Own job	Family member's job	Medicare	Medicaid	Other ²	Uninsured
1 to 9	14.0	25.6	5.1	6.2	21.9	27.2
10 to 24	25.0	29.0	2.3	7.1	11.3	25.3
25 to 99	33.3	31.7	2.1	5.7	8.1	19.2
100 to 499	39.3	35.7	1.6	4.8	5.5	12.9
500 to 999	41.3	39.4	1.1	3.3	5.5	9.3
1,000 and over	42.4	39.8	1.2	3.1	5.6	7.8
Unemployed or not in labor force	5.0	6.8	48.9	21.1	6.2	11.9
Total	28.0	29.9	11.5	7.9	8.9	14.7

¹ Firm size is that of the firm employing the worker for the longest period during the year.² "Other" includes, for example, privately purchased health insurance and Department of Veterans Affairs health care services.³ Persons reporting coverage through their own current or past employment and also reporting that they did not work during the year. These include retirees, as well as some persons who responded inaccurately to one of the questions.

Source: CRS analysis of data from the March 1993 Current Population Survey.

TABLE C-31.—NUMBER OF WORKERS WITH HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY FIRM SIZE, 1992
[Thousands]

Firm size ¹	Own job	Family member's job	Medicare	Medicaid	Other ²	Uninsured	Total
1 to 9	5,478.9	7,207.1	1,507.4	816.2	5,649.4	7,628.4	28,287.0
10 to 24	4,345.6	2,695.5	293.8	421.2	1,428.1	3,017.4	12,202.0
25 to 99	9,073.1	3,103.2	399.5	504.2	1,490.9	3,538.6	18,110.0
100 to 499	11,642.0	2,846.5	357.0	430.9	1,146.8	2,676.3	19,100.0
500 to 999	4,818.1	1,136.4	90.5	123.4	450.8	802.9	7,422.3
1,000 plus	33,262.0	6,749.7	693.2	923.7	3,006.6	4,760.5	49,396.0
Total	68,619.3	23,738.3	3,341.4	3,219.7	13,172.6	22,424.6	134,516.0

¹ Firm size is that of the firm employing the worker for the longest period during the year.

² "Other" includes, for example, privately purchased health insurance and Department of Veterans Affairs health care services.

Source: CRS analysis of data from the March 1993 Current Population Survey.

Table C-32 shows insurance coverage for workers by industry class. The industries showing the lowest rates of job-based coverage are those where employment is seasonal (as in agriculture or construction) and those that tend to use low-wage workers and/or part time workers (as in personal services, entertainment, and retail trade). Employer-provided health insurance is most common in industries with a stable work force, such as government, and those whose workers are generally in collective bargaining arrangements, such as manufacturing, transportation, and mining.

TABLE C-32.—PERCENT OF WORKERS OBTAINING HEALTH INSURANCE COVERAGE FROM SPECIFIED SOURCES, BY MAJOR INDUSTRY CLASS, 1992

Industry class ¹	Own job	Family member's job	Medicare	Medicaid	Other ²	Uninsured
Agriculture, forestry and fisheries	10.6	19.1	5.8	8.2	26.6	29.4
Mining	37.0	46.3	1.1	2.8	5.0	7.7
Construction	22.2	31.0	1.7	5.9	12.4	26.6
Manufacturing, durable goods	39.2	42.9	1.1	2.6	4.2	9.9
Manufacturing, nondurable goods	40.0	37.9	1.5	4.1	4.9	13.5
Transportation, communications, and utilities	38.9	41.1	0.8	2.3	5.6	11.1
Wholesale trade	35.4	40.5	1.2	2.2	8.9	11.7
Retail trade	25.3	26.8	2.8	8.1	12.3	24.6
Finance, insurance, and real estate .	40.6	35.9	2.1	2.3	10.1	9.0
Business and repair services	24.6	29.0	2.7	7.4	12.3	23.9
Personal services, including household	17.2	21.6	6.1	10.5	13.7	30.9
Entertainment and recreation services	27.5	24.6	4.3	7.5	13.7	22.3
Professional and related services	40.5	33.5	2.6	3.8	9.7	9.8
Public administration	41.9	44.3	1.4	1.6	6.5	4.2

¹ Industry is that in which the worker was employed the longest during the year.

² "Other" includes, for example, privately purchased health insurance and Department of Veterans Affairs health care services.

Source: CRS analysis of data from the March 1993 Current Population Survey.

One major trend in employer health benefit plans in recent years is a shift towards self-insurance, under which an employer directly assumes the financial risk for health care costs incurred by their employees. A self-insured firm may use an insurance company only to perform administrative tasks, such as claims processing, or it

may carry out these functions in-house. Some firms are "partially insured"; they retain responsibility for most health care costs but buy protection for extraordinary expenses. Because of the financial risks involved, smaller firms are more likely to buy full coverage from a health insurance company.

TABLE C-33.—INSURANCE FUNDING ARRANGEMENTS BY FIRM SIZE, 1992

[Percent of conventional plans using arrangement]

Number of employees	1 to 24	25 to 99	100 to 999	1000 or more
Fully insured	91	90	67	46
Self-insured	9	10	33	54

Source: Health Insurance Association of America, Employer Sponsored Health Insurance in Private Sector Firms, 1992.

TRENDS IN HEALTH INSURANCE COVERAGE

An examination of the trends in health insurance coverage using the Current Population Survey is problematic because the health insurance questions asked by this survey and the types of individuals surveyed were changed beginning with the March 1988 survey. These changes result in a drop in the number of uninsured from 1986 to 1987 (and later years) that is unrelated to actual changes in insurance coverage. Thus, the data for 1986 and prior years are not comparable to data for 1987 and later years.

Between 1979 and 1986, the percent of the nonaged population who were uninsured increased from 14.6 percent to 17.5 percent. The number of uninsured would have been expected to grow from 28.4 to 30.8 million simply because the overall nonaged population grew. However, the number of nonaged uninsured actually grew from 28.4 million to 36.8 million. That is, the number of uninsured increased by 8.4 million people, yet only 2.4 million or 29 percent of the growth was due to an expanding nonaged population.

Table C-34 shows trends in the nonaged uninsured for selected years from 1979 to 1992. Most of the change in health insurance coverage occurred between 1979 and 1984; from 1984 to 1986, coverage rates remained fairly constant. The number and percent of the nonaged uninsured increased each year over the 1987-92 period, with the nonaged uninsured increasing to 37.0 million persons and 16.6 percent of the population in 1992.

To examine why the uninsured increased since 1979, table C-35 displays insurance coverage by source and year.

TABLE C-34.—NUMBER AND PERCENT OF THE NONAGED POPULATION WITHOUT HEALTH INSURANCE, 1979 AND 1983-92

	1979	1983	1984	1985	1986	1987 ¹	1988 ¹	1989 ¹	1990 ¹	1991 ¹	1992 ¹
Number uninsured (millions)	28.4	34.8	36.8	36.7	36.8	30.7	32.4	33.0	34.4	35.2	37.0
Percent uninsured (percent)	14.6	16.9	17.7	17.6	17.5	14.4	15.1	15.3	15.7	15.9	16.6

¹ Data for years after 1986 are not comparable to that for 1986 and prior years because of changes in the questions asked and the population groups surveyed.

Source: Table prepared by CRS based on data from the March 1980, and the March 1984 through the March 1993 CPS. Information from 1980 to 1982 is not presented due to errors on the CPS computer tapes for those years.

TABLE C-35.—SOURCES OF HEALTH INSURANCE COVERAGE BY YEAR FOR NONAGED POPULATION, 1979 AND 1983-92

	Percentage of nonelderly population										
	1979	1983	1984	1985	1986	1987 ¹	1988 ¹	1989 ¹	1990 ¹	1991 ¹	1992 ¹
Employment-based plans:											
Covered on own job	33.1	32.5	32.6	33.1	33.4	32.9	33.0	33.4	32.6	32.3	31.3
Covered through someone else	34.3	32.1	31.4	31.2	31.4	33.4	33.1	33.5	32.6	32.3	31.7
Total employment-based	67.4	64.6	64.0	64.3	64.8	66.3	66.1	66.9	65.2	64.6	63.0
Other plans ²	17.9	18.5	18.3	18.1	17.7	19.3	18.8	17.8	19.0	19.5	20.4
Uninsured	14.6	16.9	17.7	17.6	17.5	14.4	15.1	15.3	15.7	15.9	16.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

¹ Data for years after 1986 are not comparable to that for 1986 and prior years because of changes in the questions asked and the population groups surveyed.

² Excludes persons covered by employment-based plans.

Note.—Percentages may not add to 100.0 due to rounding.

Source: Table prepared by CRS based on data from the March 1980, and the March 1984 through the March 1993 CPS. Information from 1980 to 1982 is not presented due to errors on the CPS computer tapes for those years.

The most dramatic trend shown in table C-35 is the decline from 1979 to 1986 in the percent of the non-aged population covered by employment-based plans through another family member, from 34.3 percent to 31.4 percent. This proportion declined consistently between 1979 and 1984, and then leveled off. On the other hand, the percent of the nonelderly population covered by health insurance from their own work actually increased between 1979 and 1986 from 33.1 to 33.4 percent. This coverage declined during the early 1980s but increased by nearly a full percentage point between 1983 and 1986.

Coverage through one's own job increased slightly in 1988 and 1989 and has been declining since then to 31.3 percent in 1992. Coverage from someone else's job declined slightly in 1988, rose slightly in 1989, and has declined to 31.7 percent in 1992 below the 1987 level of 33.4 percent. Coverage from plans not employment-based declined from 1987 to 1989, then increased in 1991 exceeding the 1987 level.

UNCOMPENSATED CARE COSTS IN PPS HOSPITALS, 1980-92

Uncompensated care is a term used to describe inpatient and outpatient care given to patients who are unable or unwilling to pay. It includes charity care and bad debts. Charity care is care given for which no payment is expected. Bad debt consists of charges that are not paid by uninsured individuals or partial charges, such as copayments, that are not paid by insured individuals. For this analysis, these charges have been adjusted to reflect the cost of care that was provided but not paid for.

Public hospitals and some private institutions receive government operating subsidies that at least partially offset their uncompensated care losses. These subsidies are not always directed specifically towards charity care, but they nonetheless serve to lessen the burden of a high charity care load. This analysis thus examines uncompensated care both before and net of government subsidies.

The information for this analysis was provided by the American Hospital Association from their Annual Survey of Hospitals. It describes the trend and distribution of uncompensated care in hospitals from 1980 to 1992.

The financial burden of uncompensated care increased substantially through the 1980s and continues to grow. Before offsetting operating subsidies from State and local governments, total uncompensated care costs in community hospitals increased 11.7 percent per year, reaching \$14.9 billion by 1992 (see table C-36). Over the 12-year period, this is about 1 percent faster than the growth in total hospital costs. However, this masks the slowdown that occurred in more recent years. From 1980 to 1986, uncompensated care costs grew almost 3 percent faster than total hospital costs, but from 1986 to 1992, they grew almost 1 percent slower.

The portion of uncompensated care costs that was not covered by government operating subsidies grew even faster: 13 percent per year. This is because government subsidies have not increased as fast as total hospital cost inflation, with the lag being most pronounced starting in 1988 (see chart C-1). Between 1980 and 1992, the proportion of uncompensated care costs covered by government subsidies dropped from 28 percent to 19 percent.

The burden of uncompensated care is widespread. Uncompensated care has traditionally been associated with large, urban public hospitals; over the last decade, however, the problem increasingly affected the entire industry. In 1992, uncompensated care accounted for 6 percent of hospital costs before government subsidies and 5 percent net of government subsidies (see table C-37). Urban government and major public teaching hospitals carried the largest uncompensated care burden as a percentage of total expenses both before and after government subsidies; however, they also received the most relief from government subsidies. Geographically, rural hospitals receive proportionally less support than urban hospitals. Voluntary and proprietary hospitals, on average, receive almost no relief from uncompensated care through government subsidies, although they provide an amount of uncompensated care equal to 5 percent and 4 percent of total costs, respectively.

While a hospital's uncompensated care load is an important determinant of its overall financial condition, it is not the predominant factor in predicting financial performance. Perhaps the most important factor in this regard is the degree to which hospitals are able to generate revenue from other payers and non-patient care sources to cover their uncompensated care costs and Medicaid shortfalls.

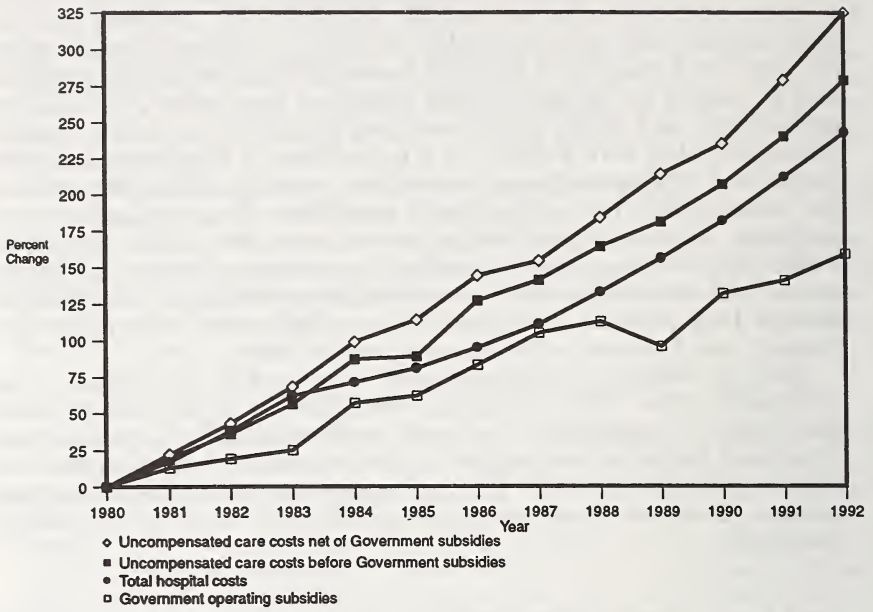
TABLE C-36.—HOSPITAL UNCOMPENSATED CARE COSTS AND GOVERNMENT OPERATING SUBSIDIES, 1980-92

Measure	Amount (in billions)				Average annual percent change		
	1980	1986	1991	1992	1980-86	1986-92	1980-92
Uncompensated care costs before government subsidies	\$3.6	\$8.9	\$13.4	\$14.9	14.7	8.9	11.7
Government operating subsidies	1.1	2.0	2.6	2.8	10.6	6.0	8.2
Uncompensated care costs net of government subsidies	2.8	6.9	10.8	12.1	16.1	9.7	12.8
Proportion of uncompensated care costs covered by government subsidies (percent)	27.7	22.3	19.6	18.9	.....	.....	.....

Note.—Includes all community hospitals.

Source: ProPAC analysis of American Hospital Association Annual Survey data.

CHART C-1. CUMULATIVE GROWTH IN UNCOMPENSATED CARE COSTS AND GOVERNMENT SUBSIDIES, 1980-92



SOURCE: ProPAC analysis of AHA Annual Survey data.

TABLE C-37.—HOSPITAL UNCOMPENSATED CARE COSTS AS A PERCENT OF TOTAL COSTS, BY HOSPITAL GROUP, 1992

[In percent]

Hospital group	Uncompensated care costs before government subsidies	Uncompensated care costs net of government subsidies
All hospitals	6.0	4.9
Large urban	6.4	4.9
Other urban	5.6	4.9
Rural	5.3	4.8
Voluntary	4.8	4.6
Proprietary	3.9	3.9
Urban government	14.4	6.9
Rural government	6.5	5.0
Major teaching:		
Public	17.9	7.3
Non-public	5.3	4.8
Other teaching	4.9	4.9
Non-teaching	4.6	4.6
Disproportionate share:		
Large urban	8.3	5.7
Other urban	6.8	5.6
Rural	6.5	6.2
Non-disproportionate share	4.2	4.1

Note: Includes data for all community hospitals, except teaching and DSH hospitals which are PPS hospitals only.

Source: ProPAC analysis of American Hospital Association Annual Survey data.

INTERNATIONAL HEALTH SPENDING ⁴

This section analyzes trends in health expenditures for 24 Organization for Economic Cooperation and Development (OECD) countries from 1970 to 1991. Table C-38 illustrates total health expenditures as a percentage of gross domestic product (GDP). In 1970, the mean percent of GDP was 5.1 percent, with the United States being 45 percent higher than the average with 7.4 percent of GDP. By 1991, the overall mean percent of GDP comprised of health expenditures had increased to 7.9 percent while the United States health spending as a share of GDP had increased to 13.4 percent, some 70 percent greater than the overall average.

The second to the last column in table C-38 presents per capita health expenditures denominated in U.S. dollars. The last column illustrates public health expenditures as a percent of total health

⁴The data and analysis in this section are from Health Affairs, "Health Care Systems in Twenty-four Countries," by George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, Fall 1991. Also, OECD press release, March 5, 1993.

spending. This ranged from 61 percent in the United States to over 90 percent in Luxembourg, Norway, Sweden, Germany, Iceland, Ireland, Spain, Switzerland, and the U.K. with an OECD average of 84.2 percent.

TABLE C-38.—TOTAL HEALTH EXPENDITURE AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT [GDP], PER CAPITA HEALTH SPENDING AND PERCENT OF MEDICAL EXPENDITURES COVERED BY PUBLIC INSURANCE SCHEME, FOR SELECTED CALENDAR YEARS 1960-91

[In percent except per capita]

Country	1960	1970	1980	1985	1990	1991	Per capita	Percent ¹
Australia	4.9	5.7	7.3	7.7	8.2	8.6	\$1,407	70.0
Austria	4.4	5.4	7.9	8.1	8.3	8.4	1,448	84.0
Belgium	3.4	4.1	6.6	7.4	7.6	7.9	1,377	86.0
Canada	5.5	7.1	7.4	8.5	9.5	10.0	1,915	84.0
Denmark	3.6	6.1	6.8	6.3	6.3	6.5	1,151	85.0
Finland	3.9	5.7	6.5	7.2	7.8	8.9	1,426	82.0
France	4.2	5.8	7.6	8.5	8.8	9.1	1,650	74.5
Germany	4.8	5.9	8.4	8.7	8.3	8.5	1,659	92.0
Greece	2.9	4.0	4.3	4.9	5.4	5.2	404	85.0
Iceland	3.5	5.2	6.4	7.1	8.3	8.4	1,447	93.0
Ireland	4.0	5.6	9.2	8.2	7.0	7.3	840	90.0
Italy	3.6	5.2	6.9	7.0	8.1	8.3	1,408	75.0
Japan	3.0	4.6	6.6	6.6	6.6	6.6	1,267	87.0
Luxembourg	N/A	4.1	6.8	6.8	7.2	7.2	1,494	91.0
Netherlands	3.9	6.0	8.0	8.0	8.2	8.3	1,360	71.0
Norway	3.3	5.0	6.6	6.4	7.4	7.6	1,305	90.0
New Zealand	4.3	5.2	7.2	6.5	7.2	7.6	1,050	N/A
Portugal	N/A	3.1	5.9	7.0	6.7	6.8	624	N/A
Spain	1.5	3.7	5.6	5.7	6.6	6.7	848	90.0
Sweden	4.7	7.2	9.4	8.8	8.6	8.6	1,443	94.0
Switzerland	3.3	5.2	7.3	7.6	7.8	7.9	1,713	91.0
Turkey	N/A	N/A	4.0	2.8	4.0	4.0	142	N/A
United Kingdom	3.9	4.5	5.8	6.0	6.2	6.6	1,035	93.0
United States	5.3	7.4	9.2	10.5	12.4	13.4	2,867	61.0
OECD Average	3.9	5.1	7.0	7.2	7.6	7.9	1,262	84.2

¹ Percent of medical expenditures covered by public insurance scheme.

Source: Schieber, George J. and Jean-Pierre Poullier. "International Health Spending: Issues and Trends." Health Affairs, Spring 1991 p. 109; Schieber, George J., Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Care Systems in Twenty-four Countries." Health Affairs, Fall 1991, p. 24. Also, OECD press release, March 5, 1993.

APPENDIX D. MEDICARE REIMBURSEMENT TO HOSPITALS

Medicare part A provides reimbursement for inpatient hospital care through a payment system based on prospectively set rates, the prospective payment system (PPS), for hospital cost reporting periods beginning on or after October 1, 1983.

Before the passage of the Social Security Amendments of 1983 (P.L. 98-21) the Medicare program reimbursed hospitals according to the reasonable costs they incurred in providing services to Medicare beneficiaries. Because the actual reasonable costs could not be determined until after the hospital had provided the services and reported its costs to the Medicare program, this method of reimbursement was known as retrospective cost-based reimbursement.

Under authority provided by the Social Security Amendments of 1972 (P.L. 92-603), the Department of Health and Human Services (HHS) placed certain limits on inpatient routine operating costs recognized as reasonable (referred to as section 223 limits for the specific section in the law). The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, commonly referred to as TEFRA) expanded previously existing limits to include all other inpatient hospital operating costs. Further, it established a new 3-year Medicare ceiling (or target rate) on the allowable annual rate of increase in operating costs per case for inpatient hospital services. TEFRA also required that HHS develop proposals for the prospective payment of hospitals under Medicare. The proposal from HHS was presented to the Congress at the end of 1982.

Legislation based on this prospective payment proposal was enacted in Public Law 98-21, which established a new method of Medicare reimbursement for hospital inpatient care—the prospective payment system (PPS). This appendix describes the major reimbursement provisions of PPS.

GENERAL SUMMARY

Medicare payment for hospital inpatient services is made according to a prospective payment system, rather than a retrospective cost-based system. Medicare payments are made at predetermined, specific rates which represent the average cost, nationwide, of treating a Medicare patient according to his or her medical condition. The classification system used to group hospital inpatients according to their diagnoses is known as diagnosis-related groups (DRGs). Separate DRG rates apply depending on whether a hospital is located in a large urban area (greater than 1 million population, or 970,000 in New England), other urban area, or rural area of the country, as determined by the Office of Management and Budget (OMB) Metropolitan Statistical Area (MSA) system.

During a 4-year transition period, a declining portion of the total prospective payment was based on a hospital's historical reasonable costs and an increasing portion was based on a combination of re-

gional and national Federal DRG rates. In the fifth year of the program (fiscal year 1988) and thereafter, Medicare payments are generally determined under a national DRG payment methodology. Special transition provisions apply to hospitals located in certain geographic regions.

If a hospital can treat a patient for less than the payment amount, it can keep the savings. If the treatment costs more, the hospital must absorb the loss. A hospital is prohibited from charging Medicare beneficiaries any amounts (except for deductibles, copayment amounts, and for services not covered by Medicare) which represent any difference between the hospital's cost of providing covered care and the Medicare DRG payment amount.

Certain hospital costs are excluded from the prospective payment system and are paid on a reasonable cost basis. In addition, certain hospitals are excluded from the new system and continue to be reimbursed on a reasonable cost basis, subject to rate of increase limits. Authority is provided for States to establish their own all-payer hospital payment systems if they meet certain Federal requirements.

BASIC PAYMENT SYSTEM

Unless excluded from the prospective payment system, each Medicare participating hospital is paid a predetermined payment rate per discharge for each type of patient treated. Types of patients are defined by the diagnosis related groups patient classification system which assigns each hospital inpatient to one of 487 patient categories (DRGs) based on the diagnosis and the type of treatment received (medical or surgical).

The payment rate for each DRG is the product of two components: a base payment amount which applies for all DRGs, and a relative weighting factor for the particular DRG. The base payment amount is intended to represent the cost of a typical (average) Medicare inpatient case. The relative weighting factor represents the relative costliness of an average case in the particular DRG compared to the cost of the overall average Medicare case (i.e., relative to the base payment amount). When the DRG relative weights are each multiplied by the base payment amount, the result is a complete set of prices for all DRGs. Separate DRG rates apply to hospitals located in large urban, other urban, or rural areas (separate base payment amounts apply in these areas, but the DRG relative weighting factors are the same). In addition, the base payment amount (and, therefore, each DRG rate) is adjusted for area differences in hospital wage levels compared to the national average hospital wage level.

Transition period

Although the transition to prospective payment rates was completed in fiscal year 1988, special transition provisions apply to hospitals located in certain geographic regions.

In a few regions with historically higher costs, Public Law 100-203 provided for the continued use of Federal amounts based in part on regional rates until September 30, 1990. Under this transition provision, known as the "regional floor," the DRG payment rate is determined as the higher of 100 percent of the national

amount, or 85 percent of the national amount plus 15 percent of the regional amount.

Public Law 101-403, the Continuing Resolution of October 1, 1990, extended the regional floor provision on a budget neutral basis through October 20, 1990. Public Law 101-508 (OBRA 1990) extended the regional floor provision for discharges occurring before October 1, 1993, not subject to budget neutrality. Public Law 103-66 (OBRA 1993) extended the provision until October 1, 1996.

Update factors

PPS payment rates are updated each year using an "update factor." The annual update factor applied to increase the Federal base payment amounts is determined, in part, by the projected increase in the hospital market basket index. The market basket index measures the cost of goods and services purchased by hospitals, yielding one price inflator for all hospitals in a given year. Table 1 shows the categories of expense used in developing the index. The update factor also includes adjustments for increases in hospital productivity, technological change, and other factors that affect the level of operating cost per discharge. The annual update factor is also adjusted to include increases in average payments per case attributable to increases in case mix due to changes in coding and reporting accuracy.

Before fiscal year 1988, the same factor was used for all hospitals; however, in subsequent years separate factors have been applied to hospitals according to their locations. Separate update factors were set for hospitals located in large urban, other urban, and rural areas. Beginning October 1, 1994, the other urban and rural standardized amounts will be equalized. Table D-2 compares the hospital market basket increases to actual updates for the past 11 years and shows the increases in PPS payments per case that resulted from the updates and other policy changes.

From October 1, 1990, through October 20, 1990, the PPS hospital update factors were set equal to the full market basket increase. Public Law 101-508 provided for a freeze in hospital payments at fiscal year 1990 levels for the period from October 21, 1990, through December 31, 1990. For this period, the market basket percentage increase applicable to PPS and PPS-exempt hospitals was deemed to be equal to zero (0) percent.

OBRA 1990 (Public Law 101-508) set separate update factors for hospitals located in large and other urban areas, and for hospitals located in rural areas. The factors were designed to eliminate the payment differential between other urban and rural hospitals by fiscal year 1995. For large and other urban hospitals, the following update factors are: for fiscal year 1991, for discharges occurring on or after January 1, 1991, the market basket increase (MBI) minus 2.0 percentage points; for fiscal year 1992, the MBI minus 1.6 percentage points; for fiscal year 1993, the MBI minus 1.55 percentage points; and for fiscal year 1994-95, the full MBI.

TABLE D-1.—HOSPITAL PROSPECTIVE PAYMENT INPUT PRICE INDEX (THE "MARKET BASKET"), EXPENSE CATEGORIES AND RATES OF PRICE CHANGE FOR SELECTED FEDERAL FISCAL YEARS.

Expense categories	Base year FFY 1987 weights ¹	FFY percentage rates of price change					
		1990(H)	1991(H)	1992(H)	1993(H)	1994(P)	1995(P)
Total	100.00	4.8	4.3	3.0	3.0	3.4	3.7
1. Wages and Salaries(L)	52.22	5.0	4.6	3.7	3.1	3.1	3.2
2. Employee Benefits(L)	9.50	7.8	7.0	6.2	5.9	5.7	6.0
3. Professional Fees(L)	1.65	4.8	4.5	4.0	3.4	3.3	3.3
4. Energy and Utilities	2.37	8.2	7.5	-5.0	1.0	4.7	3.7
A. Fuel Oil, Coal, and Other Petroleum	0.62	21.9	11.4	-14.4	-2.2	12.0	5.9
B. Electricity	1.14	2.7	7.1	1.8	1.2	0.3	1.7
C. Natural Gas	0.34	-1.2	-0.9	-1.9	10.2	4.7	2.5
D. Motor Gasoline	0.23	11.1	8.4	-11.2	-2.8	5.9	7.6
E. Water and Sewerage	0.04	6.6	6.9	7.1	5.9	5.7	5.6
5. Professional Liability Insurance	1.43	-0.6	-2.5	4.8	4.3	6.1	8.6
6. All Other	32.84	3.7	3.2	1.5	1.9	2.7	3.5
A. All Other Products	21.79	3.3	2.8	1.1	1.9	2.2	3.2
1. Pharmaceuticals	3.87	9.2	8.3	7.2	5.0	4.4	4.9
2. Food	3.30	4.1	1.8	0.9	1.3	2.6	2.8
a. Direct Purchase	2.11	3.7	0.7	0.0	1.1	2.6	2.4
b. Contract Service	1.19	4.7	3.8	2.4	1.7	2.6	3.6
3. Chemicals	3.13	-3.1	2.3	-4.4	1.5	1.2	3.7
4. Medical Instruments	2.67	3.0	1.7	1.9	2.5	2.3	2.9
5. Photographic Supplies	2.62	5.1	-0.3	-0.7	-0.8	0.7	1.7
6. Rubber and Plastics	2.32	0.7	1.9	-0.3	0.9	0.5	0.8
7. Paper Products	1.40	1.7	-0.4	-2.1	-0.4	2.1	5.2
8. Apparel	1.14	3.0	2.1	1.6	1.9	1.9	2.1
9. Machinery and Equipment	0.50	3.1	2.3	0.5	0.5	1.3	2.3

10. Miscellaneous Products	0.83	4.6	3.8	0.8	1.6	1.5	2.9
B. All Other Services	11.05	4.3	3.8	2.4	1.9	3.7	4.1
1. Business Services(L)	3.85	4.9	3.2	2.4	1.4	3.0	4.1
2. Computer Services(L)	1.99	6.9	4.1	1.3	3.1	3.5	3.6
3. Transportation and Shipping	1.23	4.1	5.7	1.0	3.1	4.4	5.0
4. Telephone	0.99	0.4	1.3	1.2	0.2	2.0	2.4
5. Blood Services(L)	0.59	0.3	-0.1	6.5	-0.2	1.4	2.6
6. Postage(L)	0.37	0.0	10.8	4.9	0.0	20.0	13.2
7. All Other Labor Intensive Services(L)	1.23	3.9	4.1	3.4	2.1	2.9	3.4
8. All Other Non-Labor Intensive Services	0.80	5.0	5.0	3.0	3.0	2.9	3.2

1 Weights may not sum to 100.00 due to rounding.

L=Considered labor-related.

H=Historical data subject to change only upon revision of underlying series.

P=Projected data subject to change in future forecasts.

FFY=Federal Fiscal Year.

Source: Health Care Financing Administration, OACT, release of the DRI/McGraw-Hill Fourth Quarter Forecast, December, 1993.

The update factors for rural hospitals are: for fiscal year 1991, for discharges occurring on or after January 1, 1991, the MBI minus 0.7 percentage points; for fiscal year 1992, the MBI minus 0.6 percentage points; for fiscal year 1993, the MBI minus 0.55 percentage points; for fiscal year 1994, the MBI plus 1.5 percentage points; and for fiscal year 1995, the amount necessary to provide rural hospitals with an average standardized amount equal to that of other urban hospitals.

OBRA 1993 (Public Law 103-66) reestablished the update factors for fiscal years 1994 and 1995; however, it still completed the transition to eliminate the payment differential between urban and rural hospitals by fiscal year 1995. The legislated update factors are as follows: for fiscal year 1994, MBI-2.5 percent for large and other urban hospitals and MBI-1.0 percent for rural hospitals; for fiscal year 1995, MBI-2.5 percent for large and other urban hospitals and "an amount necessary to equalize the rural and urban standardized amounts" for rural hospitals; in fiscal year 1996, all hospitals will receive an update of MBI-2.0 percent; in fiscal year 1997, the update for all hospitals is MBI-0.5 percent; for fiscal year 1998 and thereafter, hospitals receive the full MBI.

For fiscal year 1994, the market basket increase is estimated to be 4.3 percent, providing the following net fiscal year update factors: for large and other urban hospitals, 1.8 percent; for rural hospitals, 3.3 percent.

DRG weighting factors

Public Law 98-21 required the HHS Secretary to adjust the DRG definitions and weighting factors in fiscal year 1986 and at least every 4 years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. Public Law 99-509, however, required the Secretary to adjust the DRG definitions and weighting factors each year, beginning in fiscal year 1988.

OBRA 1989 required the Secretary to reduce the weighting factor for each DRG by 1.22 percent for discharges in fiscal year 1990. In addition, the Secretary is prohibited from adjusting DRG weighting factors on other than a budget neutral basis beginning in fiscal year 1991.

Table D-3 shows the 20 DRGs accounting for the largest numbers of Medicare inpatient discharges during fiscal year 1992. DRG relative weights appear in table D-21 at the end of this appendix.

Source and calculation of the hospital wage index

The hospital wage index is used to adjust a hospital's base payment amount for the wage level of the hospital's area. This is accomplished by multiplying the labor-related component of the Federal portion of the payment amount by a wage index. The wage index is intended to measure the average wage level for hospital workers in each urban area (metropolitan statistical area or MSA) or rural area (non-MSA parts of States) relative to the national average wage level.

TABLE D-2.—COMPARISON OF INCREASES IN HOSPITAL MARKET BASKET, PPS UPDATES, AND PPS PAYMENTS PER CASE, FISCAL YEARS 1984-94

(In percent)

Fiscal year	Increases in hospital market basket ¹	Actual update	Increase in PPS payments per case ²
1984	4.9	4.7	18.5
1985	4.0	4.5	10.5
1986	4.3	.5	3.1
1987	3.7	1.2	5.3
1988	4.7	1.5	5.8
Large urban ³		1.5	
Other urban ⁴		1.0	
Rural		3.0	
1989	5.4	3.3	6.5
Large urban		3.4	
Other urban		2.9	
Rural		3.9	
1990	5.5	⁵ 4.7	5.3
Large urban		⁵ 4.4	
Other urban		⁵ 3.7	
Rural		⁵ 8.4	
1991	5.2	3.4	5.5
Large urban		3.2	
Other urban		3.2	
Rural		4.5	
1992	4.4	3.0	4.9
Large urban		2.8	
Other urban		2.8	
Rural		3.8	
1993	4.1	2.7	3.7
Large urban		2.6	
Other urban		2.6	
Rural		3.6	
1994	4.3	2.0	2.9
Large urban		1.8	
Other urban		1.8	
Rural		3.3	

¹ Based on data available when final PPS rule was issued.² Increases for 1984 through 1991 based on data from Medicare Cost Reports, which correspond to hospital cost reporting periods, rather than Federal fiscal years. Increases for 1992 through 1994 based on PPS update and estimated case-mix index increase.³ Large urban = metropolitan areas with populations of one million or more.⁴ Other urban = metropolitan areas with populations of less than one million.⁵ Actual updates for fiscal year 1990 adjusted to reflect 1.22 percent across-the-board reduction in DRG weights.

Source: ProPAC.

TABLE D-3.—SHORT STAY HOSPITAL DISCHARGES, TWENTY DIAGNOSIS-RELATED GROUPS WITH THE MOST DISCHARGES IN FISCAL YEAR 1992

DRG description	Discharges	Percent total	Average length of stay (days)
Total, all DRGs	10,992,430	100.0	8.4
20 Leading DRGs	4,801,419	43.7	8.7
127 Heart failure and shock	662,105	6.0	7.4
89 Simple pneumonia and pleurisy ¹	393,665	3.6	8.4
14 Specific cerebrovascular disorders except transient ischemic attack	353,510	3.2	9.4
140 Angina pectoris	332,895	3.0	4.3
209 Major joint and limb reattachment procedures	300,260	2.7	9.5
88 Chronic obstructive pulmonary disease	291,325	2.7	7.2
182 Esophagitis, gastroenteritis, and miscellaneous digestive disorders	231,640	2.1	6.0
296 Nutritional and miscellaneous metabolic disorders ¹	223,210	2.0	7.9
430 Psychoses	223,175	2.0	16.9
174 G.I. Hemorrhage ²	221,200	2.0	6.6
138 Cardiac arrhythmia and conduction disorders ²	196,638	1.8	6.8
320 Kidney and urinary tract infections ¹	168,770	1.5	7.9
79 Respiratory infections and inflammations ¹	161,240	1.5	11.2
112 Vascular procedures except major reconstruction without pump	159,995	1.5	6.8
121 Circulatory disorders with acute myocardial infarction and cerebrovascular complications, discharged alive	158,276	1.4	9.1
416 Septicemia ²	154,045	1.4	10.0
462 Rehabilitation	149,510	1.4	19.0
148 Major small and large bowel procedures ²	146,625	1.3	16.8
124 Circulatory disorders except acute myocardial infarction, with cardiac catheterization and complex diagnosis	138,315	1.3	6.7
16 Transient ischemic attack & precerebral occlusions	135,020	1.2	6.2

¹ Age greater than 17, with complications.² With complications.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Until May 1, 1986, the index was based on compensation and employment data for hospital workers, for calendar year 1981, as reported to the Bureau of Labor Statistics in the U.S. Department of Labor. The wage index reflected average hospital wages in each urban and rural area as a percentage of the national average hospital wage. However, because many hospitals relied on varying proportions of part-time employment, there was a concern that the wage index tended to understate actual levels of hospital hourly wage rates in facilities that relied heavily on part-time workers.

In final regulations published on September 1, 1987 (52 FR 33039, Sept. 1, 1987), the Secretary changed the method of calculating the national average wage level, and updated the wage index data. The national average wage level was calculated by dividing national aggregate wages and salaries by the national aggregate number of paid hours of hospital employment. Under this method, the index as a whole was not likely to be sensitive to minor changes in the data for individual labor market areas.

Public Law 100-203 (OBRA 1987) required the Secretary to update the wage index by October 1, 1990, and at least every 3 years thereafter. Updates are to be based on a periodic survey of the wages and wage related costs of PPS hospitals. To the extent feasible, the survey must be designed to measure earnings and hours of paid employment by occupational category, and to permit exclusion of the wages and wage related costs hospitals incur in providing skilled nursing facility services.

OBRA 1989, required the Secretary to update the area wage index annually, beginning in fiscal year 1993, in a budget neutral manner.

For discharges occurring on or after January 1, 1991, and before October 1, 1993, OBRA 1990 requires the use of a wage index based solely on a 1988 wage survey. OBRA 1990 requires the Secretary to apply the wage index without regard to previous surveys of wages and wage-related costs. Tables D-18, D-19, and D-20, at the end of this appendix, give the current wage index values for each metropolitan area, for all rural areas in a state, and a special index for hospitals that are reclassified as urban areas.

The calculation of the index begins with the area average hospital hourly wage. For each MSA or non-MSA area (i.e., all non-MSA counties in a State) total county compensation and total paid hours data are summed separately over all counties included in the area. Then aggregate hospital compensation for the area is divided by aggregate paid hours of hospital employment in the area to produce the area average hourly wage. The hospital wage index is calculated by dividing the average hourly wage for each area by the national average hourly wage (determined by dividing national aggregate compensation by national aggregate paid hours of employment).

This procedure results in an index number, such as 0.9175 (Asheville, North Carolina) or 1.2165 (Sacramento, California), for each MSA or non-MSA area in the United States. Since the national average wage level is represented by an index value of 1.000, the wage index value for any area has a direct and simple interpretation. The value of 1.2165 for Sacramento means that the hourly

wage rate for hospital workers is 21.65 percent higher in the Sacramento MSA than nationwide.

Thus, in computing the Federal portion of the hospital payment rates applicable for hospitals in the Sacramento MSA, the labor-related component of the national large urban adjusted standardized payment amount (\$2,646.19) is multiplied by 1.2165 in order to adjust for the higher level of hourly wage rates in this area. Similarly, the calculation of the labor portion of the rates for hospitals in Asheville would involve a reduction in the published labor-related component of the national adjusted standardized payment amount, to reflect the fact that hourly wage levels in this MSA are 8.25 percent lower than the national average (as indicated by the wage index value of 0.9175).

SAMPLE PAYMENT CALCULATION

The Federal large urban, other urban, and rural base payment amounts per discharge for fiscal year 1994 were published in the Federal Register on September 1, 1993 (see table D-4). The payment rates for most hospitals are computed using the national adjusted operating standardized amounts. However, hospitals located in regions where the regional rate (sum of labor and non-labor portions) is higher than the national rate may use a blended rate equal to 85 percent of the national rate plus 15 percent of the regional rate. Puerto Rico has its own adjusted operating standardized amounts for DRG payment purposes, which are based on a blend of the Puerto Rico-specific large urban, other urban, or rural amount and a special national amount.

Each payment amount is divided into a labor-related component and a nonlabor related component. The sum of these components represents the base payment amount that would apply for a hospital located in an area with a wage index of 1.0 (i.e., average wage rates for hospital workers in the area match the national average of hospital wage rates across all areas).

The basic payment to a hospital for a case in a particular DRG is the applicable national (or blend of national and regional, if appropriate) payment amount, adjusted by the local wage index value and multiplied by the weighting factor for the DRG.

For an example of a payment calculation, assume a hospital is located in Washington, DC. Such a hospital would be in a large urban area in the South Atlantic census region. As this is not one of the regions affected by the regional floor, payment is based on the large urban national standardized amount. First, the labor-related portion of this amount (\$2,646.19 in fiscal year 1994) is multiplied by the appropriate wage index (1.0828 for Washington, DC):

$$\$2,646.19 \times 1.0828 = \$2,865.29$$

To this total is added the nonlabor-related portion of the standardized amount:

$$\$2,865.29 + \$1,090.21 = \$3,955.50$$

For each discharge, this new total is then multiplied by the relative weight factor for the DRG to which the case has been assigned. These weights range from a low of 0.1240 for DRG 382

(false labor) to a high of 19.4679 for DRG 480 (liver transplant). The payment rates for the sample hospital in fiscal year 1994 would therefore vary from a low of \$490.48 ($\$3,955.50 \times 0.1240$) to a high of \$77,005.27 ($\$3,955.50 \times 19.4679$).

In addition to the basic payment amount for each case, additional payments may be made to teaching hospitals and hospitals that serve a disproportionate share of low-income patients. Any hospital may receive additional payments for outliers (cases with extraordinarily high costs or a very long stay, relative to other cases in the DRG) and for treatment of beneficiaries with end stage renal disease. Finally, certain hospital costs are excluded from PPS and reimbursed separately. The next sections of this appendix discuss additional PPS payments and the separate reimbursement of excluded costs.

TABLE D-4.—NATIONAL AND REGIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR, FISCAL YEAR 1994

	Large urban		Other urban		Rural	
	Labor related	Nonlabor related	Labor related	Nonlabor related	Labor related	Nonlabor related
National average	\$2,646.19	\$1,090.21	\$2,604.30	\$1,072.95	\$2,698.19	\$869.31
Regional:						
New England (CT, ME, MA, NH, RI, VT)	2,778.92	1,138.39	2,734.93	1,120.37	2,991.46	1,031.69
Middle Atlantic (PA, NJ, NY)	2,496.61	1,078.50	2,457.09	1,061.43	2,864.92	975.30
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,665.05	995.33	2,622.86	979.58	2,738.74	845.71
East North Central (IL, IN, MI, OH, WI)	2,810.97	1,177.65	2,766.47	1,159.00	2,773.33	939.95
East South Central (AL, KY, MS, TN)	2,557.71	901.26	2,517.22	886.99	2,714.37	788.64
West North Central (IA, KS, MN, MO, NB, ND, SD)	2,665.81	1,073.03	2,623.60	1,056.05	2,638.17	842.55
West South Central (AR, LA, OK, TX)	2,650.47	988.59	2,608.51	972.95	2,530.11	774.85
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,556.76	1,058.92	2,516.28	1,042.16	2,558.62	891.18
Pacific (AK, CA, HI, OR, WA)	2,487.02	1,209.59	2,447.65	1,190.44	2,488.47	1,003.96
Puerto Rico:						
Regional	2,379.97	494.98	2,342.29	487.14	1,839.16	396.47
National	2,644.11	1,028.04	.....	.....	.....	.....

Source: Federal Register, September 1, 1993.

ADDITIONAL PAYMENT AMOUNTS

In addition to the DRG prospective payment rates, Medicare payments are made to hospitals for the following items or services:

Graduate medical education

Financing of graduate medical education, the period of training following medical school, is provided predominantly through inpatient revenues (both hospital payments and faculty physician fees) and a complex mix of Federal and State government funds. The federal government is the largest single explicit financing source for graduate medical education through the Medicare program and through its support of residencies in Veterans Administration hospitals. Medicare recognizes the costs of graduate medical education under two mechanisms: direct medical education payments and an indirect medical education adjustment. In fiscal year 1993, Medicare paid approximately \$1.7 billion in direct medical education payments and \$3.7 billion in indirect adjustments.

Direct medical education costs

The direct costs of approved medical education programs (such as the salaries of residents and teachers and other education costs for residents, and for nurses, and allied health professionals trained in provider-operated programs) are excluded from the prospective payment system. The direct medical education costs for the training of nurses and allied health professionals in provider-operated programs are paid for on a reasonable cost basis.

Public Law 99-272 (COBRA), replaced reasonable cost reimbursement for graduate medical education through residency training programs for physicians, with formula payments based on each hospital's per resident costs. Medicare's payment to each hospital equals the hospital's cost per full-time equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE resident amount is calculated using data from the hospital's cost reporting period that began in fiscal year 1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. The number of FTE residents is calculated at 100 percent after July 1, 1986, only for residents in their initial residency period (i.e., within the minimum number of years of formal training necessary to satisfy specialty requirements for board eligibility plus 1 year, but not to exceed 5 years). For residents not in their initial residency period, the weighing factor is 75 percent before July 1, 1987, and 50 percent after that date. On or after July 1, 1986, residents who are foreign medical graduates are not to be counted as FTE residents unless they have passed certain designated examinations.

HHS issued final regulations implementing the COBRA payment changes for graduate medical education costs on September 29, 1989. The changes are effective retroactively to 1985. OBRA 1990 prohibited the Secretary from recouping overpayments to hospitals resulting from the COBRA payment changes for graduate medical education until October 1, 1991. In addition, the act limits the

amount of the recoupment to 25 percent of the total overpayment in each of four years beginning in fiscal year 1992.

In addition, Public Law 101-508 provided for a freeze in the update applicable for graduate medical education per-resident payment amounts for portions of cost reporting periods occurring from October 21, 1990, through December 31, 1990.

Hospital-based nursing and allied health professionals education programs operated at a hospital but controlled by another institution were included in PPS payment rates until an exception was enacted in TAMRA, allowing hospitals paid under a demonstration waiver to receive reasonable cost reimbursement for the costs of the nursing school. Public Law 101-239 allowed such hospitals to continue to be reimbursed on a reasonable cost basis if, before June 15, 1989, and thereafter, the hospital incurred substantial costs in training students and operating the school, the nursing school and hospital share some common board members, and all instruction is provided at the hospital or in the immediate proximity of the hospital. In addition, hospitals paid under the TAMRA exception are allowed to be reimbursed for reasonable costs of training nursing students retroactively for hospital cost reporting periods beginning in fiscal year 1986.

OBRA 1990 provides for payment on a passthrough basis (exempt from PPS) to hospitals for the clinical training of nurses or allied health education programs that are hospital-supported, as distinct from hospital-operated. The act requires hospitals to meet specific requirements to qualify for such payments, including the requirement that hospitals must have claimed and been paid for such costs prior to October 1, 1989. The Secretary is prohibited from recouping overpayments made to such hospitals and is required to refund any overpayments already recouped.

OBRA 93 provided that the amounts paid per resident for the direct costs of graduate medical education would not be updated by the CPI for cost reporting periods beginning during fiscal years 1994 and 1995, except for primary care residents and residents in obstetrics and gynecology. Primary care residents are defined to include family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, and osteopathic general practice.

The allowable initial residency period will be defined to include only the period until the resident is first eligible for board certification, excluding the current-law allowance for one additional year. In addition, up to 2 years of a residency in preventive medicine will not count toward the limitation on the initial residency period.

The Secretary of HHS was directed to adjust the base-year payment amounts for certain grant-supported residency programs in family and community medicine, to the extent that the program is no longer supported by such grants. The base-year amounts also are adjusted for hospitals not required to pay FICA taxes or make a contribution to certain pension plans prior to enactment of the Omnibus Budget Reconciliation Act of 1990.

Indirect medical education costs

Additional payments are made to hospitals under the prospective system for the indirect costs attributable to approved medical edu-

cation programs. These indirect costs may be due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents. Congressional reports on the PPS authorizing legislation indicate that the indirect medical education payments are also to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients, increased use of diagnostic testing, and higher staff-to-patient ratios.

The additional payment to a hospital is based on a formula that provides an increase of approximately 7.7 percent in the Federal portion of the DRG payment, for each 0.1 increase in the hospital's intern and resident to bed ratio on a curvilinear basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size).

Public Law 100-647 extended the 7.7 percent indirect medical education adjustment until October 1, 1995. Public Law 101-508 makes the indirect medical education adjustment of 7.7 percent permanent.

Disproportionate share hospitals

Public Law 99-272 (COBRA) provided that additional payments would be made to hospitals that serve a disproportionate share of low-income patients; the adjustment was extended until October 1, 1990, by OBRA 1987 (Public Law 100-203) and to October 1, 1995 by Public Law 100-647, the Technical and Miscellaneous Revenue Act (TAMRA) of 1988. A hospital's disproportionate patient percentage is defined as the hospital's total number of inpatient days attributable to Federal Supplemental Security Income Medicare beneficiaries divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days.

Public Law 101-508 (OBRA 1990), revised the formulas for computing the disproportionate share adjustment, effective January 1, 1991. Table D-5 shows the minimum disproportionate patient percentages required to qualify for the adjustment and the formulas for computing the adjustment effective October 1, 1993.

TABLE D-5.—CRITERIA TO QUALIFY FOR DISPROPORTIONATE SHARE ADJUSTMENT AND FORMULAS FOR COMPUTING ADDITIONAL PAYMENT, EFFECTIVE OCTOBER 1, 1993

Type of hospital	Qualifying disproportionate patient percentage (P)	Formula or fixed percentage adjustment
Urban, 100 or more beds .	15 percent	$(P-15)(.6) .65 + 2.5$
Urban, 100 or more beds .	20.2 percent	$(P-20.2) .8 + 5.88$
Urban, 100 or more beds .	30 percent of inpatient revenue from State or local indigent care funds.	35 percent
Urban, under 100 beds	40 percent	5 percent
Rural, over 500 beds	Not specified in law; regulations set threshold at 15 percent.	Same as urban, 100 or more beds
Rural, over 100 beds	30 percent	4 percent
Rural, under 100 beds	45 percent	4 percent
Rural, sole community hospital.	30 percent	10 percent
Rural, rural referral center and—		
(a) not a sole community hospital, 100 or more beds.	30 percent	$(P-30)(.6) + 4.0$
(b) not a sole community hospital, under 100 beds.	45 percent	$(P-30)(.6) + 4.0$
(c) also a sole community hospital.	30 percent	Greater of 10 percent or $(P-30)(.6) + 4.0$

Note.—The disproportionate patient percentage (P) is equal to the sum of (a) the number of Medicare inpatient days provided to Supplemental Security Income recipients divided by total Medicare patient days, and (b) the number of inpatient days provided to Medicaid beneficiaries divided by total inpatient days.

Source: ProPAC.

ESRD beneficiary discharges

Effective with cost reporting periods beginning on or after October 1, 1984, additional payments are made to hospitals for inpatient dialysis provided to end-stage renal disease (ESRD) beneficiaries if total discharges of such beneficiaries from non-ESRD related DRGs account for 10 percent or more of the hospital's total Medicare discharges. A hospital meeting the criteria is paid an additional payment for each ESRD beneficiary discharge based on the estimated weekly cost of dialysis and the average length of stay of its ESRD beneficiaries.

Outliers

Additional amounts are paid to hospitals for atypical cases (known as "outliers") which have either extremely long length of stay (day outliers) or extraordinarily high costs (cost outliers) compared to most discharges classified in the same DRG. The law requires that total outlier payments to all hospitals covered by the system represents no less than 5 percent and no more than 6 percent of the total estimated PPS payments for the fiscal year. Effective

tive with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases meeting the criteria for cost outliers. Outlier payments are financed by an offsetting overall reduction in the Federal portion of the base payment amount per discharge. Effective October 1, 1986, Public Law 99-509 established separate urban and rural set-aside factors for financing outlier payments. The separate set-aside factors for rural and urban hospitals for financing outlier payments will end when the other urban/rural payment differential is phased out in fiscal year 1995, as enacted in OBRA 1990.

Public Law 100-203 increased payments for outlier cases classified in DRGs relating to patients with burns from April 1, 1988, through September 30, 1989. This legislation also prohibited the Secretary from issuing any final regulations before September 1, 1988, which changed the method of payment for outlier cases (other than burn cases).

The Secretary published new outlier rules on September 30, 1988, effective for discharges on or after October 1, 1988. The new rules modified the thresholds used in determining whether a case is an outlier and increased the allowable payment amounts for cost outliers. The effect of the changes increased the proportion of all outlier payments going to cost outliers. Previously, about 85 percent of outlier payments were made for length of stay outliers and 15 percent for cost outliers. Under the new rules, 60 percent of payments are made for cost outliers and 40 percent for length of stay outliers. (Cases that meet both length of stay and cost outlier criteria are paid under the policy that produces the higher payment.)

To determine the amount of additional payments for outlier cases, the length of stay (LOS) for each case in a DRG is first compared against the applicable LOS threshold for the category. If the LOS for a case exceeds the threshold, then the case qualifies as a day outlier. In this instance, the hospital is paid its regular payment rate per discharge (for this DRG), plus the Federal portion of a per diem amount (55 percent of the hospital's Federal per diem rate for the DRG) for each Medicare covered day above the LOS threshold.

If the case does *not* qualify as a day outlier, then it may qualify as a cost outlier. The case will qualify for extra payments on this basis if the hospital's Medicare covered charges for the case, adjusted to operating costs (and reduced by its indirect teaching and disproportionate share adjustments, if applicable), exceed its cost outlier threshold for the DRG. In this instance, the hospital is paid its regular payment rate per discharge for the DRG, plus the Federal portion of 75 percent of the difference between its adjusted (and reduced) charges for the case and the cost outlier threshold.

In October 1991, Medicare began a transition from cost-based to prospective payment for hospital capital expenses (see below). In the August 30, 1991, final rule implementing this change, the Secretary established a unified outlier payment system for capital and operating costs. For day outliers, payments for covered days were set equal to 60 percent of the combined per diem operating and capital payment rates for the DRG. For cost outliers, payments are made only if the combined operating and capital cost for the case

exceed the cost outlier threshold for the DRG. As in the case of operating cost payments, standard Federal capital payment amounts are reduced to establish a pool for outlier payments.

OBRA 1993 legislated two changes in outlier policy that will become effective in fiscal year 1995. First, day outliers will be phased out over a period of four years. By fiscal year 1999, all outlier payments will be based solely on cost. Second, cost-outlier thresholds will be based on a fixed amount beyond the payment rate for each case so that hospitals will incur the same loss on every case before outlier payments are applied.

Table D-6 shows the changes in outlier policy that have occurred since 1988.

TABLE D-6.—OUTLIER POLICY PARAMETERS, FISCAL YEARS 1988–94

	1988	1989 ¹	1990	1991	1992	1993	1994
Pool target	5.6% (urban), 2.5% (rural)	5.6% (urban), 2.2% (rural)	5.6% (urban), 2.2% (rural)	5.5% (urban), 2.3% (rural)	5.6% (urban), 2.1% (rural), 5.0% (capital)	5.5% (urban), 2.2% (rural), 5.0% (capital)	5.4% (urban), 2.3% (rural), 5.5% (capital)
Length of stay thresholds ²	Lesser of 18 days or 2.0 x S.D.	Lesser of 24 days or 3.0 x S.D.	Lesser of 28 days or 3.0 x S.D.	Lesser of 29 days or 3.0 x S.D.	Lesser of 32 days or 3.0 x S.D.	Lesser of 23 days or 3.0 x S.D.	Lesser of 23 days or 3.0 x S.D.
Cost thresholds	Greater of 2.0 x DRG Federal rate or \$14,000	Greater of 2.0 x DRG Federal rate or \$28,000	Greater of 2.0 x DRG Federal rate or \$34,000	Greater of 2.0 x DRG Federal rate or \$35,000	Greater of 2.0 x DRG Federal rate or \$44,000 ³	Greater of 2.0 x DRG Federal rate or \$35,500 ³	Greater of 2.0 x DRG Federal rate or \$36,000 ³
Cost-to-charge ratio used for cost outliers.	66.0%	Hospital-specific	Hospital-specific	Hospital-specific	Hospital-specific	Hospital-specific	Hospital-specific
Marginal cost factor	60.0%	60.0% (LOS), 75.0% (cost)	60.0% (LOS), 75.0% (cost)	60.0% (LOS), 75.0% (cost)	60.0% (LOS), 75.0% (cost)	55.0% (LOS), 75.0% (cost)	55.0% (LOS), 75.0% (cost)

¹ Effective for discharges after October 31, 1988. For discharges between October 1 and October 31, 1988, transitional thresholds applied as follows: length of stay, lesser of 22 days or 2 standard deviations; cost, greater of 2 times Federal rate or \$23,750.

² The LOS threshold for a DRG is set at the lesser of the national average LOS for all cases in the DRG plus a fixed number of days (e.g., 18 days in fiscal year 1988) or the national average LOS for the DRG plus a fixed number of standard deviations (e.g., 2.0 SD in fiscal year 1988). The number of days represented by a fixed number of standard deviations varies among the DRG categories.

³ Combined operating/capital cost threshold.

Source: Annual Federal Register notices.

PAYMENT FOR CAPITAL

Until fiscal year 1992, Medicare paid its proportionate share of hospitals' reasonable capital-related costs, based on services used by beneficiaries as a proportion of total services furnished by the hospital. (Payments in recent years have been subject to fixed percentage reductions to be described below.) Four basic types of costs are allowable for Medicare reimbursement:

- (1) Interest on mortgages, bonds, or other borrowing used to finance capital investments or current operations. Interest costs are generally offset by any interest income earned by the hospital on investments.

- (2) Depreciation, figured on a straight line basis, for plant and equipment, but not for land.

- (3) Rental payments for plant and equipment.

- (4) Property taxes and insurance premiums related to capital assets.

One other type of capital cost was formerly recognized under Medicare, but has not been reimbursable for hospital services since fiscal year 1989: return on equity for investor-owned hospitals. Return on equity payments provided a return to investors equivalent to what they would have earned if they had used their money for some other purpose.

When the new PPS system was enacted in 1983, Congress excluded capital costs. However, the Secretary was instructed to report to Congress on methods for including capital in PPS and was authorized (but not required) to implement prospective payment for capital on or after October 1, 1986.

The Secretary's authority to include capital in PPS was postponed twice. The Supplemental Appropriations Act of 1986 (Public Law 99-349) delayed prospective capital payment until October 1, 1987. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) delayed prospective payment until October 1, 1991. However, the Secretary was required, not merely authorized, to implement a prospective system by that date. The system was required to provide for capital payments to be made on a per-discharge basis, with adjustments based on each discharge's classification under the DRGs or some similar system. At the Secretary's discretion, the system could include adjustments to reflect variations in costs of construction or borrowing, exceptions (including exceptions for hospitals with existing obligations), and adjustments to reflect hospital occupancy rates.

While prospective payment for capital has been delayed, Congress has included in budget reconciliation legislation fixed percentage reductions in amounts otherwise payable by Medicare for capital costs. These cuts began in fiscal year 1987, with a 3.5 percent reduction. Medicare would compute its share of total costs for each hospital and then reduce that computed share by 3.5 percent. The percentage reduction increased to 7 percent for the first quarter of fiscal year 1988, 12 percent for the rest of that fiscal year, and 15 percent for fiscal year 1989 through fiscal year 1991. (Delays in completing budget legislation have meant that there were brief intervals in 1987 and 1989 when no reduction was taken). The reductions originally applied only to capital costs relat-

ed to inpatient care. Beginning in fiscal year 1990, capital payments for outpatient hospital services were also reduced. (The reductions did not apply to certain types of rural hospitals defined in Medicare law, including sole community hospitals, essential access community hospitals, and rural primary care hospitals.)

The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) continued capital payment reductions through fiscal year 1995, with the reduction percentage lowered to 10 percent for fiscal year 1992 through 1995. Because prospective payment began in fiscal year 1992, the reductions are not applied directly to each hospital's computed capital costs. Instead, the Secretary is required to set payments under the new system (or under the new system and PPS combined) in such a way as to achieve an aggregate inpatient hospital capital spending reduction of 10 percent, as compared to what would have been spent under the reasonable cost system. The Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) extended the 10 percent reduction in outpatient capital payment through fiscal year 1998.

The administration's proposed rules for prospective payment for capital costs were published in the Federal Register on February 28, 1991. After a period for public comment, final rules were published on Aug. 30, 1991. The final rule provides for a 10-year transition to fully prospective payment beginning October 1, 1991.

Under the rule, the Secretary establishes a standard per case capital payment rate, based on average capital costs per case in fiscal year 1989 and updated for inflation and other factors. The base rate is adjusted in order to meet the requirement that capital payment rates be set in such a way as to achieve an aggregate saving of 10 percent relative to what would have been paid under a full cost system. For fiscal year 1993 the standard Federal payment rate for capital is \$417.29 (\$320.99 in Puerto Rico). Rates are adjusted using the DRG weights and a geographic factor based on area wage indices.

Hospitals in large urban areas receive a 3 percent increase and hospitals in Alaska and Hawaii receive a cost of living adjustment. A disproportionate share adjustment is provided for urban hospitals with more than 100 beds. A hospital receives approximately a 2.1 percent point increase in capital payments for each 10 percent increment in its disproportionate share percentage.

An adjustment is also made for the indirect costs of medical education. This adjustment is based on the ratio of residents to average daily inpatient census. Capital payments increase approximately 2.8 percentage points for each 10 percent increment in the residents to average daily census ratio. Additional capital payments are issued for outlier cases.

During a transition period that ends September 30, 2000, each individual hospital's capital payment rate is a blended rate based partly on its own historic capital costs and partly on the Federal rate. In fiscal year 1993, rates are 80 percent hospital-specific and 20 percent Federal. The hospital-specific portion will drop by 10 percent a year, until fully Federal rates take effect in fiscal year 2001.

The Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) reduced the Federal rate for inpatient capital expenses by 7.4 percent to correct for inflation forecast errors.

The transition rules include two provisions to assist hospitals most disadvantaged by the shift to prospective payment: a "hold harmless" payment system and exception payments for certain facilities. Hospitals with base year capital costs above average continue to be paid on a cost basis for the portion of their costs related to "old" capital investments (generally assets put in use or obligated by the end of 1990). The rest of the hospital's capital payments are based on the prospective rates. For example, if 75 percent of a hospital's costs are for depreciation and interest on a pre-1990 building, the hospital is paid Medicare's share of those costs (subject to the current 10 percent reduction). For "new" capital, it receives a portion of the prospective rate based on the hospital's own ratio of new to total capital. In this case, because old capital accounts for 75 percent of costs, the hospital's new capital payment is 25 percent of the prospective rate for each case treated. This hold harmless payment system will continue until the end of the 10-year transition, or until a hospital's old capital costs drop to the point at which it is more advantageous for the hospital to shift to fully prospective payment.

Exception payments are made to hospitals whose capital payments under the new system fall significantly short of their actual capital costs. Most hospitals are assured of receiving a minimum of 70 percent of costs. Specified urban hospitals with a disproportionate share of low-income patients receive at least 80 percent of costs, and rural sole community hospitals at least 90 percent. Computation of exception payments is cumulative. If a hospital received more than the minimum in one year but a shortfall the next, the surplus from the first year would be applied before any additional payment would be made in the second year.

Table D-7 shows the distribution of estimated total capital payments to PPS hospitals by geographic location and type of hospital for fiscal year 1994.

Table D-8 shows two sets of projections of the level and the rate of increase of aggregate payments and payments per case for capital-related costs in fiscal years 1984 through 1999.

Both sets of projections for capital reflect recently enacted provisions which phase out payments for a return on equity capital for proprietary providers. The second set also includes the anticipated effects of statutory reductions in reimbursements for capital-related costs (i.e., 3.5 percent for portions of cost-reporting periods in fiscal year 1987, 12 percent for fiscal year 1988, 15 percent for fiscal year 1989 and the last three quarters of fiscal year 1990, 15 percent in fiscal year 1991, and 10 percent for fiscal years 1992-95) enacted in the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), in the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), and in the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508). The second set of estimates in table 7 also include the effect of regulations implementing prospective payment for inpatient capital-related costs (effective in fiscal

year 1992), including the budget neutrality requirement through fiscal year 1995 enacted in OBRA 1990.

TABLE D-7.—CAPITAL-RELATED PAYMENTS TO PPS HOSPITALS (INCURRED AMOUNTS FOR FISCAL YEAR 1994)

Hospital group	Number of hospitals ¹	Medicare discharges (in thousands)	Capital payments (in millions of dollars)	PPS and capital payments (in millions of dollars)	Capital payments as a percentage of PPS and capital payments
All hospitals	5,350	10,397	\$8,030	\$74,780	10.7
Large MSA ²	1,637	4,730	4,130	39,620	10.4
Other urban	1,352	3,635	2,850	25,490	11.2
Rural	2,361	2,032	1,040	9,680	10.8
Urban, 99 or fewer beds	757	480	300	2,600	11.6
Urban, 100 to 199 beds	901	1,654	1,300	11,010	11.8
Urban, 200 to 299 beds	611	2,121	1,680	15,290	11.0
Urban, 300 to 499 beds	529	2,643	2,260	21,550	10.5
Urban, 500 or more beds					
	191	1,467	1,450	14,660	9.9
Rural, 49 or fewer beds	1,208	376	140	1,470	9.7
Rural, 50 to 99 beds	718	630	300	2,780	10.8
Rural, 100 to 149 beds .	223	379	210	1,890	11.2
Rural, 150 to 199 beds .	106	257	140	1,300	10.8
Rural, 200 or more beds	106	389	240	2,240	10.9
By Payment Classification:					
Large MSA	1,816	5,236	4,530	43,110	10.5
Other urban	1,430	3,435	2,630	23,540	11.2
Rural referral	205	557	340	3,210	10.7
Rural sole community ³	563	325	150	1,560	9.8
Other rural	1,336	824	350	3,340	10.5
Teaching, 100 or more residents	225	1,253	1,350	14,680	9.2
Teaching, fewer than 100 residents	816	3,065	2,510	23,570	10.6
Nonteaching	4,309	6,078	4,170	36,540	11.4
Disproportionate share ⁴	1,832	4,713	4,010	38,190	10.5
Nondisproportionate share	3,518	5,684	4,020	36,590	11.0
Urban, by Region:					
New England	172	535	440	4,330	10.2
Middle Atlantic	447	1,620	1,370	13,920	9.9
South Atlantic	453	1,380	1,160	10,280	11.3
East North Central	498	1,488	1,140	11,080	10.2
East South Central	170	530	440	3,650	11.9
West North Central	188	532	430	3,990	10.8
West South Central	382	818	750	5,940	12.6
Mountain	126	326	280	2,470	11.1
Pacific	503	1,043	950	9,160	10.3
Puerto Rico	50	95	30	290	11.3

TABLE D-7.—CAPITAL-RELATED PAYMENTS TO PPS HOSPITALS (INCURRED AMOUNTS FOR FISCAL YEAR 1994)—Continued

Hospital group	Number of hospitals ¹	Medicare discharges (in thousands)	Capital payments (in millions of dollars)	PPS and capital payments (in millions of dollars)	Capital payments as a percentage of PPS and capital payments
Rural, by Region:					
New England	53	58	30	330	9.8
Middle Atlantic	85	150	80	800	9.6
South Atlantic	303	392	220	1,920	11.3
East North Central	313	330	170	1,570	10.6
East South Central	290	325	160	1,420	11.0
West North Central	552	298	140	1,320	10.6
West South Central	365	260	130	1,140	11.2
Mountain	244	115	70	590	11.6
Pacific	151	99	50	560	9.6
Puerto Rico	5	5	NA	NA	NA
Voluntary ⁵	3,028	7,673	5,990	56,430	10.6
Proprietary	779	1,230	1,070	8,330	12.9
Government	1,514	1,480	950	9,920	9.6

¹ Number of hospitals for which data were available.

² "Large MSA" indicates Metropolitan Statistical Areas with more than 1 million people or New England County Metropolitan Areas with more than 970,000 people.

³ Sole community hospitals that are also rural referral centers are included in the rural referral category.

⁴ Hospitals that receive a disproportionate share adjustment for treating a relatively high proportion of low-income patients.

⁵ Ownership type was not available for 29 hospitals.

NA—not available.

Note.—PPS payments are the payments to PPS hospitals for the operating costs of providing inpatient services to Medicare enrollees, including enrollees' copayments. Capital payments are Medicare's payments for the capital-related expenses of providing inpatient care. Unless otherwise indicated "urban" and "rural" categories are based on hospitals' geographic locations. Numbers may not add to totals because of rounding.

Source: Congressional Budget Office estimates based on data from the Health Care Financing Administration and the Prospective Payment Assessment Commission.

PAYMENTS ON A REASONABLE COST BASIS

Costs for certain items are excluded from the prospective payment system and thus are not included in the prospective payment rates. Medicare pays for its share of the following costs according to the former reasonable cost-based system:

Physicians in teaching hospitals

If a teaching hospital so elects, the direct medical and surgical services of physicians in such hospitals will be excluded from the prospective payment system and paid for on the basis of reasonable costs.

TABLE D-8.—ESTIMATED OUTLAYS FOR INPATIENT CAPITAL-RELATED COSTS UNDER MEDICARE'S HOSPITAL INSURANCE PROGRAM, FISCAL YEARS 1984-99¹

	Without OBRA 1986, 1987, 1989, 1993 percentage reductions and without Aug. 30, 1991 regulation			With OBRA 1986, 1987, 1989, 1990, 1993 percentage reductions and with Aug. 30, 1991 regulation ²		
	Aggregate payments (billions)	Year to year per- cent in- crease	Payments per case	Aggregate payments (billions)	Year to year per- cent in- crease	Payments per case
Fiscal year:						
1984	\$3.5	NA	\$310	\$3.5	NA	\$310
1985	4.0	15.8	380	4.0	15.8	380
1986	4.4	8.9	425	4.4	8.9	425
1987	4.7	6.8	460	4.5	1.4	440
1988	5.0	7.0	490	4.4	-1.0	430
1989	5.2	3.8	505	4.2	-4.2	410
1990	5.7	9.2	545	5.2	21.8	495
1991	6.4	11.7	605	6.0	15.3	570
1992	7.6	18.6	685	6.9	14.1	620
1993	8.6	13.3	760	7.7	11.7	680
1994	9.5	11.3	820	8.4	9.4	720
1995	10.6	11.3	885	9.3	10.9	775
1996	11.7	10.6	950	10.2	9.5	825
1997	12.9	9.9	1,015	11.1	9.2	875
1998	14.1	9.3	1,080	12.1	9.1	930
1999	15.3	8.8	1,160	13.2	9.0	990

¹Both projections for capital-related payments reflect current law provisions which phased out payments for return-on-equity capital for proprietary providers during fiscal year 1987 through fiscal year 1989. Estimates are CBO's February 1991, projections.

²Includes freeze at fiscal year 1987 payment levels from Oct. 1, 1987, through Nov. 20, 1987; percentage reductions were 3.5 percent in fiscal year 1987, 12 percent in fiscal year 1988, 15 percent in fiscal year 1989, 15 percent in the last three quarters of fiscal year 1990, 15 percent in fiscal year 1991, and 10 percent for fiscal years 1992-95. Under current law, regulations implementing (effective fiscal year 1992) prospective payment for inpatient capital-related costs will primarily affect the distribution of payments with aggregate levels not to exceed those projected above, for fiscal year 1992 through fiscal year 1995. Final regulation on prospective payment of capital issued on Aug. 30, 1991, implements budget neutrality requirements of OBRA 1990 through fiscal year 1995. Payment rates are updated thereafter by the 2-year moving average increase in Medicare capital costs per case, adjusted for case mix change, that occurred 3 and 4 years previous to the fiscal year in question.

Organ acquisition costs

The estimated net expenses associated with Medicare organ acquisition in certified transplantation centers are excluded from the prospective payment system and paid on a reasonable cost basis.

Passthrough payments for hemophilia inpatients

OBRA 1989 excluded the cost of administering blood clotting factors for hemophilia inpatients from PPS, for items furnished from June 19, 1990, through December 19, 1991. OBRA 1993 further extended this provision through fiscal year 1994. The price per unit for the blood clotting factors was set at a predetermined rate, in consultation with ProPAC, and the cost of administering the blood clotting factors was determined by multiplying a predetermined price per unit of blood clotting factor by the number of units provided to the individual.

Bad debts of Medicare beneficiaries

An additional payment is made to hospitals for bad debts attributable to unpaid deductible and copayment amounts related to covered services received by Medicare beneficiaries.

The Secretary is prohibited from making any change in the policy in effect on August 1, 1987, including changes in hospital documentation requirements. OBRA 1989 prohibits the Secretary from requiring hospitals to change their bad debt collection policy if a fiscal intermediary accepted the policy in accordance with the rules in effect as of August 1, 1987, for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency. For such facilities, the Secretary also may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

SPECIAL TREATMENT OF CERTAIN FACILITIES

Certain exceptions and adjustments to the prospective payment rates are provided as follows:

Sole community hospitals

Sole community hospitals (SCHs) are hospitals that (because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals) are the sole source of inpatient services reasonably available in a geographic area. For cost reporting periods beginning before April 1, 1990, SCHs were paid on the same basis as all other hospitals were paid in the first year of the transition period: 25 percent of the payment is based on Federal regional DRG rates and 75 percent on each hospital's cost base.

Under the provisions of OBRA 89, the criteria for SCH designation was liberalized by allowing hospitals to be designated as such if they were located more than 35 road miles from another hospital. In addition, OBRA 89 provided the Secretary with the authority to designate a hospital as an SCH if, by reason of factors such as travel time to the nearest alternative source of appropriate inpatient care, location, weather conditions, travel conditions, or absence of other like hospitals, the Secretary determines that it is the

sole source of inpatient hospital services reasonably available to individuals in a geographic area.

In addition, OBRA 1989 established new payment provisions that apply to all SCHs for cost reporting periods beginning after April 1, 1990. An SCH may receive the higher of the following rates as the basis of reimbursement: a target amount based on 100 percent hospital-specific prospective rates based on fiscal year 1982 costs updated to the present; a target amount based on hospital-specific prospective rates based on fiscal year 1987 costs updated to the present; or the Federal PPS rate. Current SCHs not meeting the new criteria are allowed to continue to qualify for payments as an SCH.

OBRA 1989 made permanent the provision by which an SCH may request additional payments if the hospital experiences a decrease of more than 5 percent in its total inpatient cases due to circumstances beyond its control. An SCH may receive such payments if it meets sole community hospital criteria but is not being paid as a sole community hospital. As of September 1992, 607 hospitals were classified as sole community providers.

Medicare dependent hospitals

OBRA 1989 created a new classification of hospitals termed Medicare dependent hospitals. Medicare dependent hospitals are hospitals that are located in a rural area, have 100 beds or less, are not classified as a sole community provider, and for which not less than 60 percent of inpatient days or discharges in the hospital cost reporting period that began during fiscal year 1987 were attributable to Medicare. These hospitals are reimbursed in the same fashion as sole community providers during cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993. As of September 1992, there were 501 Medicare dependent hospitals. OBRA 1993 (Public Law 103-66) extended additional payments to Medicare dependent hospitals through September 30, 1994, on a phase-down basis.

Referral centers

The Secretary is authorized to provide exceptions and adjustments as appropriate for regional and national referral centers. These centers are defined as:

- (1) rural hospitals having 275 or more beds;
- (2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries are furnished to those who live 25 miles or more from the hospital; or
- (3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985:
 - (a) a case mix index equal to or greater than the median case mix for all urban hospitals (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs. (The case mix index is a measure of

the relative costliness of the hospital's mixture of cases among the DRGs compared to the national average mixture of medicare cases);

(b) a minimum of 5,000 discharges, the national discharge criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and

(c) at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Referral centers are paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index. The applicable amount is the "other urban" rate (i.e., the rate for urban areas with 1 million or fewer people) for all referral centers except those (if any) located in MSAs greater than 1 million.

Under the regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period. Public Law 99-509 permitted hospitals designated as regional referral centers, as of the date of enactment, to continue their designation through cost reporting periods beginning before October 1, 1989. OBRA 89 extended the status of current referral centers for three additional years, including all hospitals classified as referral centers as of September 30, 1989. OBRA 93 extended the classification through fiscal year 1994 for those classified on September 30, 1992. As of September 1992, 180 hospitals were qualified as referral centers.

Hospitals in rural counties treated as urban counties

Hospitals in areas that are reclassified from urban to rural under OMB's MSA system are allowed a 2-year transition period during which they are paid a blend of the applicable urban and rural rates.

Public Law 100-203 provided for the reclassification of rural hospitals as urban if the county in which the hospital was located was adjacent to two or more MSAs and met criteria regarding commuting patterns of its residents to the central counties of the adjacent MSAs. For fiscal year 1993, 50 rural hospitals have been reclassified under this provision. If treating a hospital located in a rural county as being located in an urban area reduced the wage index for that urban area or for other rural areas in the State, Public Law 100-647 required an adjustment to ensure that, for discharges during fiscal year 1990 and 1991, no other area suffered a reduced wage index.

Public Law 101-239 (OBRA 1989) allows hospitals to apply for reclassification from rural to urban and allows counties to apply for reclassification from rural to urban. In addition, OBRA 1989 establishes a floor for area wage indices so that the reclassification of hospitals under the new procedures or the rules enacted in OBRA

1987 cannot result in the reduction of a county's wage index below the wage index for other rural areas within the same State.

Public Law 101-239 requires the Secretary to establish a Geographic Classification Review Board to consider appeals by hospitals for a change in classification from rural to urban, or from one urban area to another urban area. Reclassification may be for use of an adjacent area's standardized amount (large or other urban) or use of its wage index. The Secretary has provided by regulation that a hospital must be in a county adjacent to the area to which it seeks reclassification.

The Act also revises the rules for the adjustment of wage indices required as a result of the reclassification of hospitals under the OBRA 1987 provision or under the new procedures for reclassification. If reclassification of a county into an urban area reduces the wage index for that area by 1 percent or less, then the MSA wage index applies to hospitals in the reclassified county, but the reclassified county is to be excluded from the computation of the index. If the reclassification reduces the urban area's wage index by more than 1 percent, separate wage indices are to be computed for the original urban area and for the reclassified county. If the reclassification of a rural county results in a reduction in the wage index for the other rural counties in the State, the index is to be computed as if the reclassification had not occurred. Finally, no reclassification can reduce any area's wage index to a level below the index for rural areas in the State. The new rules are effective April 1, 1990.

OBRA 1990 provided that if including wages of all redesignated hospitals in the wage index of the MSA to which they are redesignated reduces the MSA's wage index by more than 1 percentage point, then the original wage index (calculated without the wages of the redesignated hospitals) is applied to hospitals in the MSA. Redesignated hospitals would receive a wage index combining their wages plus the wages of the MSA to which they were redesignated. OBRA 1990 also extended the due date for initial applications for reclassification submitted to the Geographic Classification Review Board until November 6, 1990, and clarifies the Secretary's ability to review decisions of the Board. For fiscal year 1993, 823 rural hospitals (34 percent) and 370 urban hospitals (13 percent) have been reclassified by the Board.

In a final rule issued September 1, 1992, the Secretary provided that, beginning in fiscal year 1994, no hospital may be reclassified for wage index purposes unless its hourly wages equal 108 percent of the average for its current area and 84 percent (90 percent if weighted for occupational categories) of the average for the area to which it seeks reclassification.

Section 602k hospitals

Prior to Public Law 98-21, payments for nonphysician services (in such areas as radiology, laboratory, physical therapy, prosthetics) provided to Medicare beneficiaries who were hospital inpatients were made either (1) to the hospital under part A of Medicare on a reasonable cost basis or (2) to an outside supplier of the service under part B of Medicare on the basis of reasonable charges. The

practice of billing under part B for services provided to hospital inpatients is known as the "unbundling" of part A services.

Public Law 98-21 provided that, effective October 1, 1983, for all hospitals participating in the Medicare program (including those under prospective payment, excluded hospitals, and those paid under State cost control systems), all nonphysician services provided to hospital inpatients will be paid only as hospital services under the part A program. The Secretary has authority to waive this requirement during the transition period to allow billing under part B for hospitals that had such extensive billings under part B prior to October 1, 1982, that compliance with the new requirement would threaten the stability of patient care (commonly referred to as 602k hospitals). As of December 1985, there were four 602k hospitals.

HOSPITALS EXCLUDED FROM THE PROSPECTIVE PAYMENT SYSTEM

The following hospitals are by law excluded from the prospective payment system and are paid on the basis of reasonable costs, subject to the TEFRA rate of increase limits: psychiatric hospitals, rehabilitation hospitals, psychiatric or rehabilitation units which are distinct parts of a hospital, alcohol and drug abuse hospitals and such distinct units of hospitals (for cost reporting periods beginning before October 1, 1987), children's hospitals (with patients averaging under 18 years of age), long-term hospitals (with an average inpatient length of stay greater than 25 days), and hospitals outside the 50 States and the District of Columbia. Public Law 99-509 provided that hospitals located in Puerto Rico will be included in PPS, specially adjusted for Puerto Rico, effective with discharges occurring on or after October 1, 1987. Public Law 101-239 exempts cancer hospitals (hospitals extensively involved in treatment for and research on cancer) classified as such before December 31, 1990, from PPS. In addition, the act provides an exemption for any hospital classified as a cancer hospital before December 31, 1991, that is located in a State that has a PPS waiver under section 1814(b) (i.e., Maryland). In addition, there are special cases where the prospective payment system is not applied, such as for emergency services provided to Medicare beneficiaries in hospitals not participating in Medicare and Veterans' Administration hospital services provided to Medicare beneficiaries.

OBRA 1990 increased the cost limits imposed on hospitals exempt from PPS. Under prior law, hospitals with costs in excess of the cost limits imposed by the Tax Equity and Fiscal Responsibility Act (TEFRA) would be reimbursed for their cost up to the TEFRA limit. Under OBRA 1990, hospitals with costs in excess of the cost limits imposed by TEFRA will receive 50 percent of the costs that are in excess of the limit, up to a maximum of 110 percent of the limit. In addition, the Secretary is directed to develop a new prospective payment methodology for exempt hospitals, or to substantially modify the current target-rate system.

OBRA 1993 provided for an update factor to the cost limits of market basket minus 1.0 percentage point for fiscal years 1994 through 1997. A hospital with operating costs in fiscal year 1990 that exceed the target amount by more than 10 percent are exempt

from the update reduction, with partial reductions applied to hospitals near the threshold.

Hospitals reimbursed under approved State cost control systems are also excluded from the prospective rates.

Section 1886(c) of the Social Security Act (as added by TEFRA) gave the HHS Secretary discretion to reimburse hospitals in a State according to the State's hospital reimbursement control system rather than according to Medicare's reimbursement methods if the State requests this change and if HHS determines that the State system meets certain requirements. Currently one State has a waiver to operate its own system: Maryland. New York has a waiver covering four counties participating in the Finger Lakes Area Hospital Corporation (FLAHC) rural hospital payment demonstration.

Public Laws 98-21 and 98-369 added several more requirements for State systems. According to final regulations published by HHS on April 24, 1986 (51 F.R. 15481), implementing these legislative changes, HHS has the discretion to allow Medicare hospital reimbursement to be made in accordance with a State reimbursement control system if the chief executive officer of the State requests approval of the State system, and provided that the State system:

(a) Applies to substantially all non-federal acute care hospitals in the State.

(b) Applies to at least 75 percent of all inpatient revenues or expenses for the State.

(c) Provides assurances that payers, hospital employees and patients in the State will be treated equitably under its system.

(d) Provides assurances that its system will not result in greater Medicare expenditures over 36-month periods.

(e) Does not preclude health maintenance organizations (HMOs) or competitive medical plans (CMPs) from negotiating directly with hospitals concerning payment for inpatient services.

(f) Limits hospital charges to Medicare beneficiaries to deductibles, coinsurance, and services for which the beneficiary would not be entitled to have payment made under Medicare part A; and prohibits payment under part B of Medicare for nonphysician services provided to hospital inpatients unless this prohibition is waived.

Public Law 101-239 (OBRA 1989) requires the Secretary's test of effectiveness of a State cost containment system to be based on the aggregate rate of increase from October 1, 1984, to the most recent date for which annual data are available. This provision extends the waiver for the FLAHC rural hospital payment demonstration.

Special provisions apply to States that have existing demonstration projects approved by HCFA under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendment of 1972 for the operation of State reimbursement control systems. HHS approval of a State's application to continue the operation of a system upon expiration of the demonstration project is mandatory if, and for so long as, the system meets the minimum requirements described in items (a) through (f) above.

Public Law 101-508 revises the Secretary's test of effectiveness of a State cost containment system to be based on the rate of increase in costs per hospital inpatient admission as compared to the rate of increase in such costs with respect to all hospitals between January 1, 1981, and the present. In addition, OBRA 1990 provides that a State no longer qualifying for a PPS waiver be provided with a reasonable period, not to exceed two years, for transition from the State system to the national payment system, and requires restoration of the waiver if the State returns to compliance during the transition period.

ADMINISTRATION

Prospective Payment Assessment Commission

Public Law 98-21 required the Director of the Congressional Office of Technology Assessment (OTA) to appoint by April 1, 1984, a commission of 15 independent experts, known as the Prospective Payment Assessment Commission (ProPAC). Public Law 99-272 added two members to ProPAC, bringing the total to 17 members.

The Commission must report to Congress by March 1 of each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy.¹

The Secretary is required to submit to Congress recommendations that take into account ProPAC's recommendations, and include a written explanation of those recommendations that differ from those of the Commission.

By June 1 of each year, ProPAC also submits a report to Congress which provides background information on trends in health care delivery and financing, including the impact of the prospective payment system on providers and beneficiaries.²

Administrative and judicial review

Administrative and judicial appeals are allowed under procedures and authorities already established under the Medicare program. However, the law precludes administrative and judicial review of: (1) the "budget neutrality" adjustment (see above), and (2) the DRG payment amounts, including the establishment of DRGs, the methodology for classifying discharges within DRGs, and the DRG weighting factors.

Review activities

Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (known as TEFRA) replaced the existing Professional Standards Review Organization (PSRO) program with the utilization and quality control peer review program. The Secretary of the Department of Health and Human Services was required to enter into performance-based contracts with physician-sponsored or physician-access organizations known as Peer Review Organizations (PRO's) by November 15, 1984. As a condition of receiving payments under the prospective payment system, hospitals are re-

¹ See Prospective Payment Assessment Commission. Report and Recommendation to the Secretary, U.S. Department of Health and Human Services, March 1, 1994.

² See Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System. Report to Congress, June 1993.

quired to enter into an agreement with a PRO under which the PRO will review the validity of diagnostic and procedural information provided by the hospitals; the completeness, adequacy and quality of care provided; and the appropriateness of admissions patterns, discharges, lengths of stay, transfers, and services furnished in outlier cases.

Since 1982, the statute governing the PRO program has been amended numerous times, and the PROs are now operating under the third "scope of work." In addition to reviewing inpatient care and some ambulatory care services, the PROs are now required to review hospital readmissions within 31 days of a previous hospital discharge to determine if the previous inpatient services and the posthospital services met professionally recognized standards of care. This provision was enacted as part of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), partly in response to congressional concerns that the prospective payment system was encouraging hospitals to discharge patients prematurely to inappropriate levels of care.

HISTORICAL TRENDS IN PPS PAYMENTS AND HOSPITAL MEDICARE COST, REVENUE, AND UTILIZATION

Aggregate PPS payments

Prospective payment system (PPS) payments for fiscal year 1992 are estimated at \$58.5 billion (see table D-9). Of that amount, \$6.1 billion is accounted for by beneficiary deductibles and copayments and payments made by other third-party payers, and \$52.3 billion by payments from the Medicare program. Under current law, PPS payments are expected to exceed \$91.6 billion by fiscal year 1998, with \$81.8 billion coming from the Medicare trust fund and \$9.8 billion from beneficiaries and other payers.

Trends in PPS costs, revenues, and margins

In the following tables, references to PPS1 through PPS8 indicate the first through the eighth years of operation of the Medicare prospective payment system. Hospitals were phased into PPS beginning October 1, 1983, depending on when the hospital's accounting or fiscal year began. Thus, PPS1 is the first year of prospective payment for each individual hospital and generally overlaps Federal fiscal years 1984 and 1985.

The increase in the PPS payment rates (DRG prices) has differed from the update factor each year. For example, in the first 2 years, the PPS payment rates were required to be adjusted so that aggregate payments to hospitals included in PPS would be equal to the aggregate payments they would have received if they had been paid under the provisions of prior law (the target rate of increase limits established in TEFRA, Public Law 97-248). As a result of this budget neutrality adjustment, the actual increases in the DRG prices were lower than the increases provided by the PPS update factors for those years. In the third year, the PPS rates were frozen by the Congress, and the update factor of 0.5 percent established in COBRA (Public Law 99-272) applied for only the last 5 months of the fiscal year. DRG rate increases in each year also have been affected by changes in policy that required recalculation or adjust-

ment of the Federal base payment amounts or the DRG relative weights.

Actual annual increases in average payments per case, in turn, depend on a variety of factors in addition to the increase in the PPS rates, including the increase in reported case mix and other changes in payment policies.

Following an increase of only 1.9 percent in the first year of PPS, PPS operating costs per discharge rose about 10 percent per year during the second and third years, and about 9 percent in the fourth through sixth years. However, the rate of increase declined in the seventh and eighth years, to 8.3 percent and 7.3 percent, respectively (see table D-10). PPS payment per discharge increases were substantial during the first 2 years of PPS, but were dramatically lower in the next 6 years. In each year, per discharge payments have grown faster than the PPS market basket index. PPS payment increases have also been greater than the update factor, primarily because of the increased frequency of higher-weighted DRGs. The cumulative increases in costs and payments per discharge in the first 8 years of PPS are 86.9 percent and 77.9 percent, respectively (see chart D-1).

PPS margins are defined as PPS payments less PPS operating costs divided by PPS payments. The aggregate PPS margin was above 14 percent in each of the first 2 years of PPS, falling to 1.0 percent in the sixth year, -1.5 percent by the seventh year, and -3.4 percent in the eighth year (see table D-11). The seventh year of PPS was the first year in which aggregate PPS operating costs exceeded aggregate payments. Sixty-three percent of all hospitals incurred losses under PPS during the eighth year, compared with only 17 percent in the first year (see table D-12).

PPS margins do not represent the bottom line for the hospital industry. Total margins, which include expenses and revenues related to Medicare and other inpatient and outpatient care as well as other facility activities, increased steadily from the early 1970s to the early 1980s, peaking in 1984. After a slight decline, the total margin has been increasing slightly in the past few years, from 3.5 percent in PPS5 to 4.5 percent in PPS8. These margins are comparable to pre-PPS levels.

Margins by hospital type

PPS margins vary by hospital type. During the first 4 years of PPS, urban hospitals had substantially higher margins than rural hospitals. Within both categories, margins increased with bed size. The urban/rural margin differential decreased in the fifth year, because policy changes in recent years have increased payments to rural hospitals relative to urban hospitals. In the eighth year, both the urban and rural margins were negative, but the difference between the two margins was 1.3 percentage points, compared with 7.4 percentage points in the first year. Major teaching hospitals and large urban hospitals with disproportionate shares of poor patients had relatively high margins during the first 8 years of PPS.

Distribution of PPS hospitals, cases, and payments

Estimates for fiscal year 1993 show that PPS payments continue to vary substantially across hospital groups (see table D-13). For

example, 53 percent of all PPS hospitals are located in urban areas; these hospitals account for 78 percent of all PPS discharges and receive 86 percent of all PPS payments. By contrast, rural hospitals account for 47 percent of PPS hospitals and 22 percent of PPS discharges and 14 percent of PPS payments.

The IME adjustment is intended to recognize hospitals' indirect costs of operating approved graduate medical education programs. The DSH adjustment is intended to compensate hospitals that treat large proportions of low-income patients. Almost all IME and DSH payments go to hospitals located in urban areas. In fiscal year 1993, urban hospitals received 98 percent of IME payments and 95 percent of DSH payments.

Outlier payments are intended to protect hospitals from the risk of financial losses due to cases with exceptionally long stays or high costs. Large, urban teaching hospitals and those located in the Middle Atlantic region received the highest proportion of outlier payments. Small urban hospitals, all rural hospitals, and hospitals located in the Mountain region received the lowest percentage of outlier payments.

For all PPS hospitals, the basic DRG payment was estimated to account for 86 percent of fiscal year 1993 PPS payments (see table D-14). Indirect medical education, disproportionate share, and outlier payments were expected to account for 14 percent of all PPS payments, or about \$9.2 billion. The basic DRG payment comprised more than a 10 percent greater proportion of the payments to rural hospitals (96 percent) than to urban hospitals (85 percent), due to the urban hospitals' greater reliance on outlier, IME, and DSH payments. These additional payments accounted for 16 percent of payments to urban hospitals, but only 4 percent of payments to rural hospitals.

Effects of policy changes on PPS payments

Since the implementation of PPS, the distribution of Medicare payments to hospitals has changed. Some redistribution has resulted from changes in hospital behavior, but much of it is attributable to policy decisions. These include the transition to national average rates, reductions in teaching hospital payments, the addition of a disproportionate share adjustment and increases in the size of that adjustment for many hospitals, and large update factors for rural hospitals in recent years.

The update factor and other policy decisions implemented between fiscal years 1984 and 1993 increased per-case PPS payment rates by 28.4 percent (see table D-15). These policy decisions have redistributed PPS payments to rural hospitals, particularly to sole community hospitals. Small rural hospitals have been helped much more than large hospitals in any location, while urban hospitals with fewer than 100 beds have fared worse than most groups. Similarly, major teaching hospitals received relatively little benefit from payment policy changes. On a regional basis, the hospitals in the Northeast benefitted the most from these changes while those in the Mid-Atlantic region gained the least.

The Medicare case-mix index (CMI) reflects the mix of each hospital's cases across DRGs. Because hospitals are paid on this basis, an increase in the CMI results in a proportional increase in PPS

payments. CMI changes have, in some instances, partially offset the intended effects of policy decisions. For example, case mix change has shifted payments toward urban hospitals, teaching hospitals, and large hospitals.

Over the last 10 years, the combined effects of update factors, policy decisions, and CMI growth increased per case PPS payments by 64 percent across all hospitals. Overall, rural hospitals, especially sole community hospitals, reaped gains from these changes while Mid-Atlantic and small urban hospitals received the smallest cumulative increases in their payments.

Additional hospital data

Table D-16 displays summary characteristics of hospitals participating in the Medicare prospective payment system. These data are derived from PPS payment simulations by the Congressional Budget Office.

TABLE D-9.—ESTIMATED INCURRED PPS PAYMENTS TO HOSPITALS, BY PAYMENT TYPE, FISCAL YEARS 1992–99

[In billions]

Payment type	1992	1993	1994	1995	1996	1997	1998	1999
Gross PPS payments ...	\$58.5	\$62.5	\$66.8	\$71.0	\$75.4	\$81.0	\$87.2	\$94.2
Indirect teaching	3.3	3.3	3.6	3.9	4.2	4.5	4.9	5.4
Disproportionate share	2.3	3.0	3.3	3.5	3.8	4.1	4.4	4.9
Outlier ¹	2.5	3.2	3.4	3.6	3.8	4.1	4.4	4.8
Less copayments	(6.1)	(6.1)	(6.5)	(6.9)	(7.3)	(7.8)	(8.3)	(8.8)
Net payment from Medicare	52.3	56.3	60.3	64.1	68.1	73.2	78.9	85.2

¹ Outlier payments due to the indirect medical education adjustment are included in the indirect teaching payments; outlier payments due to the disproportionate share adjustment are included in the disproportionate share payments.

Source: Congressional Budget Office.

TABLE D-10.—PERCENT CHANGE IN PPS OPERATING COSTS, PAYMENTS, AND DISCHARGES, FIRST 8 YEARS OF PPS

Year ¹	Operat- ing costs	Pay- ments	Dis- charges	Operat- ing costs per dis- charge	Pay- ments per dis- charge	Market basket	Update factor
PPS1	-4.6	11.0	-6.3	1.9	18.5	4.9	4.7
PPS2	4.3	4.2	-5.7	10.6	10.5	3.9	4.5
PPS3	5.7	-0.6	-3.6	9.7	3.1	3.9	0.5
PPS4	7.5	3.8	-1.4	9.0	5.3	3.7	1.2
PPS5	10.0	6.6	0.8	9.2	5.8	4.7	1.5
PPS6	10.5	7.7	1.1	9.3	6.5	5.4	3.3
PPS7	10.7	7.6	2.2	8.3	5.3	4.5	² 4.7
PPS8	9.7	7.8	2.2	7.3	5.5	4.3	3.4
Cumulative effect:							
PPS1				1.9	18.5	4.9	4.7
PPS2				12.7	30.9	9.0	9.4
PPS3				23.6	35.0	13.2	10.0
PPS4				34.8	42.2	17.4	11.2
PPS5				47.2	50.4	23.0	12.9
PPS6				60.8	60.2	29.6	16.6
PPS7				74.2	68.7	35.4	22.1
PPS8				86.9	77.9	36.9	22.9

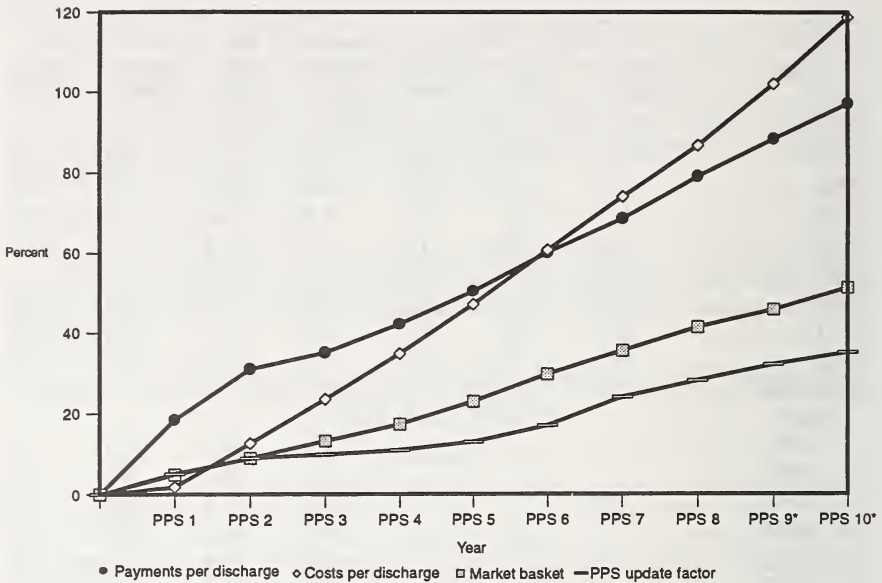
¹Data on costs, payments and cases are for hospital accounting years beginning during each Federal fiscal year. Data on the market basket and update factor are from the corresponding Federal fiscal year (1984 for PPS1, etc.).

²Adjusted for 1.22 percent across-the-board reduction in DRG weights for fiscal year 1990.

Note.—Hospitals in Maryland, Massachusetts, New Jersey, and New York excluded from PPS1 and PPS2. Hospitals in Maryland and New Jersey also excluded from PPS3 through PPS5. Data based on cohorts of hospitals with cost reports available in each 2 successive years.

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

CHART D-1.—CUMULATIVE INCREASES IN PPS MARKET BASKET, UPDATE, AND PAYMENTS AND COSTS, FIRST 10 YEARS OF PPS, IN PERCENT



* Costs and payments are estimated for PPS 9 and PPS 10.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

TABLE D-11.—PPS OPERATING MARGINS, BY HOSPITAL GROUP, FIRST 8 YEARS OF PPS
[In percent]

Hospital group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8
All hospitals	14.5	14.4	9.8	6.9	3.6	1.0	-1.5	-3.4
Urban	15.8	15.5	10.9	7.8	4.3	1.6	-1.1	-3.2
Rural	8.4	8.8	3.3	1.1	-0.4	-2.2	-3.9	-4.5
Large urban	16.5	15.5	11.1	7.8	4.2	1.6	-0.3	-1.7
Other urban	14.9	15.4	10.7	8.0	4.5	1.5	-2.1	-5.0
Rural referral	10.1	13.6	8.7	6.0	4.1	1.6	-2.1	-3.4
Sole community	8.5	6.9	2.3	0.8	-1.9	-4.4	-2.5	-2.0
Other rural	7.5	6.5	0.1	-2.3	-3.1	-4.3	-5.6	-6.2
Major teaching	19.4	21.3	16.5	14.1	11.1	8.5	7.1	8.7
Other teaching	16.5	16.3	11.9	8.6	5.1	2.7	0.0	-1.8
Non-teaching	12.3	11.6	6.5	3.5	0.7	-2.1	-5.0	-7.3
Disproportionate share:								
Large urban	17.0	16.0	12.4	10.2	8.1	6.0	4.9	4.1
Other urban	14.9	16.1	11.9	9.6	6.8	4.3	1.4	-0.7
Rural	9.6	10.3	3.8	2.0	0.9	0.4	-0.4	-0.8
Non-disproportionate share	13.8	13.5	8.3	4.7	0.8	-2.1	-5.1	-7.2
Payment adjustments:								
IME and DSH	17.4	17.9	14.2	12.0	9.7	7.5	5.7	4.7
IME only	17.0	17.3	12.0	8.0	2.9	0.4	-2.3	-3.8
DSH only	12.9	12.3	7.4	5.1	3.0	0.9	-1.3	-3.2
No IME or DSH	12.0	11.2	6.1	2.7	-0.5	-3.6	-6.9	-9.4
Urban <100 beds	13.2	12.3	6.7	3.9	0.9	-1.2	-4.0	-8.3
Urban 100-199 beds	14.3	12.9	8.2	5.7	2.8	-0.4	-3.5	-5.3
Urban 200-299 beds	15.0	14.0	9.4	5.7	2.4	-0.5	-3.3	-5.4
Urban 300-399 beds	16.1	15.8	11.4	8.2	4.8	2.3	-0.6	-3.1
Urban 400-499 beds	15.6	17.5	13.6	10.0	6.1	3.5	1.1	-1.0
Urban 500+ beds	19.0	18.9	14.0	11.5	7.3	4.1	2.0	0.5
Rural <50 beds	6.3	5.7	-0.2	-1.0	-1.6	-1.6	-2.3	-4.1
Rural 50-99 beds	8.8	7.2	1.7	-0.3	-1.9	-3.0	-3.2	-3.3
Rural 100-149 beds	8.8	8.1	3.0	1.0	-0.3	-2.1	-3.4	-3.7
Rural 150-199 beds	7.9	9.9	4.5	2.3	1.5	-1.4	-5.2	-5.1
Rural 200+ beds	10.0	13.7	7.4	3.4	1.0	-2.4	-5.5	-6.6
Voluntary	15.0	15.1	10.5	7.5	4.0	1.5	-1.1	-3.3
Proprietary	14.7	13.0	8.1	4.9	1.4	-2.3	-5.0	-4.8
Urban government	15.2	15.1	10.3	7.8	5.7	3.1	0.7	-1.5
Rural government	7.2	6.3	0.6	-1.8	-2.1	-3.7	-4.4	-5.5
Rural government	7.2	6.3	0.6	-1.8	-2.1	-3.7	-4.4	-5.5

Notes.—Data for each PPS year (PPS 1, PPS 2, etc.) correspond to each hospital's cost reporting period beginning in that year. For instance, the PPS 1 year includes data from each hospital's cost report beginning during the first year of PPS (Federal fiscal year 1984). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York, beginning with PPS 3; and includes hospitals in New Jersey, beginning with PPS 6.

IME=Indirect medical education payments.

DSH=Disproportionate share payments.

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

TABLE D-12.—DISTRIBUTION OF PPS OPERATING MARGINS, AND PERCENTAGE OF HOSPITALS WITH NEGATIVE MARGINS, FIRST 8 YEARS OF PPS

Percentile	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8
10th	-6.7	-8.4	-14.6	-18.1	-23.0	-24.9	-27.6	-29.9
25th	3.4	2.1	-3.4	-6.4	-9.3	-11.5	-13.9	-16.5
Median	11.2	10.7	5.7	3.8	1.5	-0.8	-3.0	-4.9
75th	17.7	17.8	13.4	11.9	10.6	8.9	7.2	5.8
90th	23.1	24.2	19.5	18.8	18.3	17.2	16.2	14.5
Percentage of hospitals with negative PPS operating margins	16.8	18.7	31.7	39.1	46.0	52.1	57.5	62.6

Note.—Data for each PPS year (PPS 1, PPS 2, etc.) correspond to each hospital's cost reporting period beginning in that year. For instance, the PPS 1 year includes data from each hospital's cost report beginning during the first year of PPS (federal fiscal year 1984). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York, beginning with PPS 3; and New Jersey, beginning with PPS 6.

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

TABLE D-13.—DISTRIBUTION OF PPS HOSPITALS AND DISCHARGES AND ESTIMATED FISCAL YEAR 1993 PPS PAYMENTS, BY HOSPITAL GROUP

Hospital group	Number of hospitals	PPS hospitals (percent)	PPS discharges (percent)	PPS operating payments (percent)		
				Total	Outlier	IME
						DSH
All hospitals	5,329	100	100	100	100	100
Urban	2,845	53	78	86	93	95
Rural	2,484	47	22	14	7	5
Large urban	1,447	27	41	48	54	58
Other urban	1,398	26	38	37	40	37
Rural referral	236	4	6	5	3	2
Sole community	583	11	4	2	1	1
Other rural	1,665	31	12	7	3	2
Major teaching	225	4	10	16	20	34
Other teaching	805	15	31	34	38	33
Non-teaching	4,299	81	59	49	42	33
Disproportionate share:						
Large urban	606	11	17	24	27	58
Other urban	592	11	18	19	19	37
Rural	438	8	5	3	2	5
Non-disproportionate share	3,693	69	60	54	52	0
Payment adjustments:						
IME and DSH	563	11	21	29	33	67
IME only	467	9	20	22	24	0
DSH only	1,073	20	19	17	14	33
No IME or DSH	3,226	61	40	32	28	0
Urban <100 beds	663	12	4	3	2	(1)
Urban 100-199 beds	857	16	15	14	12	17
Urban 200-299 beds	605	11	20	20	20	18
Urban 300-399 beds	343	6	15	17	18	20

TABLE D-13.—DISTRIBUTION OF PPS HOSPITALS AND DISCHARGES AND ESTIMATED FISCAL YEAR 1993 PPS PAYMENTS, BY HOSPITAL GROUP—Continued

Hospital group	Number of hospitals	PPS hospitals (percent)	PPS discharges (percent)	PPS operating payments (percent)		
				Total	Outlier	IME
Urban 400–499 beds	184	3	10	12	15	19
Urban 500+ beds	193	4	14	19	25	47
Rural <50 beds	1,230	23	4	2	(1)	(1)
Rural 50–99 beds	760	14	7	4	1	(1)
Rural 100–149 beds	258	5	4	3	1	(1)
Rural 150–199 beds	121	2	3	2	1	(1)
Rural 200+ beds	115	2	4	3	3	1
New England	228	4	6	6	7	11
Middle Atlantic	547	10	17	20	29	32
South Atlantic	761	14	17	16	17	11
East North Central	820	15	18	17	12	21
East South Central	466	9	8	7	7	3
West North Central	747	14	8	7	5	7
West South Central	753	14	11	9	9	5
Mountain	350	7	4	4	4	2
Pacific	657	12	11	13	11	9
Voluntary	3,036	57	74	75	77	79
Proprietary	773	15	12	11	12	2
Urban government	403	8	8	9	10	18
Rural government	1,087	20	7	4	1	(1)

¹ Less than 0.5 percent.

Note.—PPS payments estimated using PPS rules in effect as of January 1, 1993. Excludes hospitals in Maryland. Columns may not add to 100 due to rounding. IME = indirect medical education payments. DSH = disproportionate share payments.

Source: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1991 MedPAR file data from the Health Care Financing Administration.

TABLE D-14.—DISTRIBUTION OF ESTIMATED FISCAL YEAR 1993 PPS PAYMENTS, BY
PAYMENT TYPE AND HOSPITAL GROUP

[In percent]

Hospital group	PPS operating payments			
	Basic DRG	Outlier	IME	DSH
All hospitals	85.9	4.3	5.6	4.1
Urban	84.2	4.7	6.5	4.6
Rural	95.9	2.0	0.6	1.5
Large urban	82.1	4.8	8.1	5.0
Other urban	86.9	4.6	4.4	4.1
Rural referral	94.2	2.6	1.4	1.7
Sole community	97.6	1.2	(1)	1.2
Other rural	96.6	1.8	0.2	1.4
Major teaching	64.8	5.2	21.4	8.6
Other teaching	85.1	4.8	6.2	3.9
Non-teaching	93.5	3.7	0.0	2.8
Disproportionate share:				
Large urban	73.9	4.9	11.1	10.1
Other urban	81.6	4.3	6.0	8.1
Rural	89.8	2.3	1.5	6.4
Non-disproportionate share	92.4	4.2	3.4	0.0
Payment adjustments:				
IME and DSH	72.4	4.9	13.1	9.5
IME only	86.7	4.8	8.5	0.0
DSH only	88.1	3.7	0.0	8.2
No IME or DSH	96.3	3.7	0.0	0.0
Urban <100 beds	96.0	3.0	0.6	0.3
Urban 100-199 beds	89.7	3.7	1.6	4.9
Urban 200-299 beds	88.5	4.4	3.4	3.7
Urban 300-399 beds	85.1	4.7	5.3	4.9
Urban 400-499 beds	80.8	5.4	9.1	4.7
Urban 500+ beds	75.0	5.5	13.7	5.7
Rural <50 beds	98.9	0.5	(1)	0.6
Rural 50-99 beds	98.1	1.2	(1)	0.7
Rural 100-149 beds	95.8	2.1	0.2	1.9
Rural 150-199 beds	95.8	2.6	0.3	1.3
Rural 200+ beds	91.7	3.4	2.3	2.6
New England	83.7	4.7	9.6	2.0
Middle Atlantic	79.6	6.3	9.2	4.9
South Atlantic	86.6	4.6	3.8	5.0
East North Central	87.3	3.1	6.8	2.8
East South Central	88.1	4.2	2.7	5.0
West North Central	90.1	2.9	5.3	1.7

TABLE D-14.—DISTRIBUTION OF ESTIMATED FISCAL YEAR 1993 PPS PAYMENTS, BY
PAYMENT TYPE AND HOSPITAL GROUP—Continued

[In percent]

Hospital group	PPS operating payments			
	Basic DRG	Outlier	IME	DSH
West South Central	87.9	4.1	2.9	5.1
Mountain	91.2	3.8	3.3	1.8
Pacific	87.0	3.5	3.7	5.8
Voluntary	86.1	4.4	6.0	3.6
Proprietary	90.4	4.8	1.1	3.7
Urban government	74.9	4.4	10.8	9.9
Rural government	95.9	1.5	0.4	2.3

¹ Less than 0.5 percent.

Notes.—PPS payments estimated using PPS rules in effect as of January 1, 1993. Excludes hospitals in Maryland. Columns may not add to 100 due to rounding. DRG=diagnosis-related group. IME=indirect medical education payments. DSH=disproportionate share payments.

Source: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1991 MedPAR file data from the Health Care Financing Administration.

TABLE D-15.—EFFECTS OF PPS UPDATE FACTORS AND OTHER PAYMENT POLICY CHANGES ON PER-CASE PPS PAYMENT RATE, BY HOSPITAL GROUP

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[In percent]

Hospital group	Fiscal year				Fiscal years 1984-93			
	1984-89	1990	1991	1992	1993	Total PPS policy ef- fect	Cumu- lative in- crease in case-mix index ¹	Total case mix and policy ef- fect
All hospitals	10.3	5.2	4.5	2.3	3.6	28.4	28.0	64.4
Urban	7.8	4.4	4.2	1.2	4.0	23.4	30.2	60.7
Rural	16.7	9.2	5.1	7.7	2.1	47.2	17.9	73.6
Large urban	8.0	4.4	4.4	0.7	3.9	23.2	29.9	60.1
Other urban	7.9	4.5	4.0	1.8	4.0	24.2	30.4	62.0
Rural referral	7.2	7.3	3.1	8.4	2.8	32.0	23.9	63.6
Sole community	18.6	15.1	8.7	5.2	2.7	60.3	14.1	82.8
Other rural	20.3	8.5	5.1	8.0	1.5	50.3	14.7	72.4
Major teaching	-0.8	4.8	6.6	0.6	4.3	16.3	36.9	59.1
Other teaching	7.4	4.5	3.8	1.6	3.9	22.8	31.6	61.6
Non-teaching	13.4	5.5	4.3	3.1	3.3	33.0	24.0	64.9
Disproportionate share:								
Large urban	8.6	5.5	5.7	0.9	4.0	27.2	31.1	66.7
Other urban	8.8	5.1	4.5	2.7	3.8	27.3	30.6	66.3
Rural	14.5	9.9	5.8	10.4	2.7	51.0	19.1	79.8
Non-disproportionate share	10.9	4.9	3.9	2.1	3.5	27.7	26.9	62.1
Payment adjustments:								
IME and DSH	5.6	5.2	5.3	1.3	4.1	23.3	33.6	64.7
IME only	5.4	4.1	3.8	1.2	3.9	19.6	32.1	58.1
DSH only	13.8	5.9	5.1	4.1	3.5	36.3	24.8	70.0
No IME or DSH	13.1	5.3	3.9	2.7	3.2	31.2	23.7	62.3
Urban <100 beds	8.6	3.0	3.2	0.5	3.2	19.8	18.2	41.6
Urban 100-199 beds	10.3	4.1	4.2	1.6	3.8	26.1	23.5	55.8
Urban 200-299 beds	9.0	3.8	4.3	1.1	3.9	24.0	27.7	58.4
Urban 300-399 beds	8.3	4.9	3.9	1.3	4.0	24.4	31.4	63.4
Urban 400-499 beds	6.1	5.2	4.0	1.0	3.9	21.7	33.6	62.7
Urban 500+ beds	2.9	4.3	4.4	1.2	4.4	18.3	37.3	62.4

TABLE D-15.—EFFECTS OF PPS UPDATE FACTORS AND OTHER PAYMENT POLICY CHANGES ON PER-CASE PPS PAYMENT RATE,
BY HOSPITAL GROUP—Continued

[In percent]

Hospital group	Fiscal year				Fiscal years 1984-93			
	1984-89	1990	1991	1992	1993	Total PPS policy ef- fect	Cumu- lative in- crease in case-mix index ¹	Total case mix and policy ef- fect
Rural <50 beds	20.9	12.4	5.8	5.1	0.8	52.1	7.4	63.3
Rural 50-99 beds	19.3	10.2	6.0	7.0	1.8	51.8	14.2	73.3
Rural 100-149 beds	15.8	8.5	5.0	8.6	2.4	46.7	19.9	76.0
Rural 150-199 beds	12.4	7.8	3.7	8.6	2.8	40.3	19.5	67.7
Rural 200 + beds	7.9	6.6	4.7	9.1	2.9	35.2	25.6	69.7
New England	13.0	4.5	8.0	1.8	4.0	34.9	21.1	63.4
Middle Atlantic	3.2	5.4	4.0	0.5	3.6	17.9	27.2	50.0
South Atlantic	8.8	5.3	7.0	3.2	4.0	31.6	30.5	71.8
East North Central	8.4	4.2	3.0	2.8	3.2	23.4	27.1	56.8
East South Central	9.2	6.5	4.5	3.5	3.9	30.7	27.8	67.0
West North Central	16.0	6.0	2.1	3.1	2.8	33.0	28.4	70.8
West South Central	10.6	6.8	3.5	2.9	4.0	30.8	31.1	71.4
Mountain	8.8	5.3	4.8	2.4	3.5	27.2	26.6	61.0
Pacific	14.6	4.0	4.5	1.6	3.6	31.1	26.9	66.4
Voluntary	9.6	4.9	4.2	2.1	3.6	26.7	27.8	61.9
Proprietary	9.0	5.0	5.1	2.4	4.3	28.4	33.9	71.9
Urban government	8.2	5.5	5.2	0.6	4.0	25.5	29.5	62.5
Rural government	17.8	10.1	5.5	7.3	1.9	49.6	14.4	71.2

¹The estimated effect of the change in case mix for fiscal years 1992 and 1993 by group is based on the actual annual rate of change by group for fiscal years 1985 through 1991.

Note.—Figures are not estimates of actual changes in fiscal year PPS hospital payments. They are meant to isolate the effects of changes in PPS rules on PPS payment rates, holding all other factors constant. Payments for each year are estimated based on the PPS rules in effect on the last day of the fiscal year. The effect of change in case mix is reflected only in the last two columns. Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York beginning with fiscal year 1987 and New Jersey beginning with fiscal year 1989. IME=indirect medical education payments. DSH=disproportionate share payments.

Source: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1991 MedPAR file data from the Health Care Financing Administration.

TABLE D-16.—SUMMARY CHARACTERISTICS OF PPS HOSPITALS, BY HOSPITAL GROUP

Hospital group	Number of hospitals ¹	Estimated Medicare discharges (thousands, 1995)	Average number of beds (1992)	Estimated average case mix (1995) ²	Average wage index (1994) ³	Estimated PPS payment (dollars per case, 1995) ⁴
All hospitals	5,350	10,661	151	1.50	0.99	\$6,660
Urban	2,989	8,578	217	1.54	1.02	7,190
Rural	2,361	2,083	69	1.26	0.81	4,460
Large MSA ⁵	1,637	4,850	234	1.55	1.09	7,770
Other urban	1,352	3,727	195	1.54	0.92	6,450
Rural referral	248	710	188	1.40	0.83	5,140
Rural sole community ⁶	579	345	50	1.19	0.81	4,550
Other rural	1,534	1,028	57	1.18	0.79	3,960
Major teaching ⁷	233	1,064	448	1.72	1.11	11,360
Other teaching	808	3,365	294	1.58	1.00	7,260
Nonteaching	4,309	6,233	109	1.39	0.94	5,530
Disproportionate share: ⁸						
Large MSA	735	2,257	280	1.57	1.10	8,840
Other urban	630	2,015	243	1.56	0.91	6,850
Rural	467	561	97	1.27	0.79	4,620
Nondisproportionate share	3,518	5,828	116	1.46	0.98	5,940
Urban, 50 or fewer beds	322	111	34	1.16	1.00	4,650
Urban, 51 to 100 beds	463	419	76	1.28	0.99	5,090
Urban, 101 to 200 beds	888	1,694	146	1.39	1.01	6,110
Urban, 201 to 400 beds	954	3,837	284	1.53	1.01	6,900
Urban, 401 or more beds	362	2,517	557	1.70	1.04	8,830
Rural, 50 or fewer beds	1,252	409	32	1.10	0.79	3,750
Rural, 51 to 100 beds	684	634	72	1.21	0.80	4,160
Rural, 101 to 200 beds	320	644	138	1.30	0.82	4,660
Rural, 201 or more beds	105	396	273	1.43	0.83	5,320
New England	225	608	175	1.47	1.13	7,310
Middle Atlantic	532	1,815	254	1.48	1.12	7,760
South Atlantic	756	1,816	176	1.53	0.91	6,340

TABLE D-16.—SUMMARY CHARACTERISTICS OF PPS HOSPITALS, BY HOSPITAL GROUP—Continued

Hospital group	Number of hospitals ¹	Estimated Medicare discharges (thousands, 1995)	Average number of beds (1992)	Estimated average case mix (1995) ²	Average wage index (1994) ³	Estimated PPS payment (dollars per case, 1995) ⁴
East North Central	811	1,864	172	1.49	0.96	6,470
East South Central	460	877	138	1.44	0.82	5,450
West North Central	740	851	91	1.51	0.89	5,930
West South Central	747	1,105	126	1.50	0.87	5,980
Mountain	370	452	95	1.52	0.97	6,400
Pacific	654	1,171	143	1.54	1.20	7,910
Puerto Rico	55	103	172	1.33	0.50	2,790
Government, Urban ⁵	451	867	199	1.55	0.99	7,940
Government, Rural	1,063	650	55	1.19	0.78	4,120
Voluntary, Urban	1,940	6,652	241	1.55	1.03	7,210
Voluntary, Rural	1,088	1,216	81	1.29	0.83	4,630
Proprietary, Urban	576	1,045	154	1.51	0.98	6,460
Proprietary, Rural	203	217	78	1.28	0.82	4,500

¹ Number of hospitals for which data were available.² Weighted by case-mix-adjusted PPS payments.³ Weighted by wage-index-adjusted PPS payments.⁴ Incurred payments (including copayments) divided by the number of Medicare discharges.⁵ Hospitals located in Metropolitan Statistical Areas with more than 1 million people or New England County Metropolitan Areas with more than 970,000 people.⁶ Sole community hospitals that are also rural referral centers are included in the rural referral category.⁷ Teaching hospitals for which the ratio of the number of full-time-equivalent interns and residents to the number of beds is .25 or larger.⁸ Hospitals that receive a disproportionate share adjustment for treating a relatively high proportion of low-income patients.⁹ Ownership type was not available for 29 hospitals.

Note.—Years refer to federal fiscal years. Urban and rural categories are based on hospitals' geographic locations.

Source: Congressional Budget Office estimates based on data from the Health Care Financing Administration and the Prospective Payment Assessment Commission.

TABLE D-17.—HISTORICAL TRENDS IN FACTORS AFFECTING PPS RATES AND AVERAGE PAYMENTS PER CASE

[Percentage change from previous year]

	Fiscal year—													
	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Market basket index ¹ ...	8.1	5.5	4.9	4.1	2.9	3.2	4.7	5.4	5.5	5.2	2.4	3.1	4.3	4.7
Annual update factor ⁴ .	.....	.....	.....	.....	.....	1.15	1.76	3.33	5.71	2.83	2.99	2.73	2.04	2.61
Case mix index ⁵ .....	.....	.....	8.4	3.1	2.5	2.1	3.2	2.5	0.84	2.5	1.4	1.3	2.0	2.0
Average payments per discharge ⁶	13.8	10.2	10.8	15.0	8.0	3.6	2.8	13.0	8.4	4.9	7.3	4.7	5.0	4.8
Average payments per beneficiary ⁶	15.2	11.4	7.8	6.6	1.5	-0.3	1.2	9.4	8.1	3.8	10.3	5.8	6.1	6.2

¹ Estimates as published in the Federal Register for fiscal years 1982–94; fiscal year 1995 President's Budget assumptions shown for fiscal year 1995.² 4.7 for hospitals excluded from the prospective payment system.³ 4.2 for hospitals excluded from the prospective payment system.⁴ Estimates as published in the Federal Register for fiscal years 1987–94; fiscal year 1995 President's Budget assumptions used for fiscal year 1995.⁵ Estimates based on historical data for fiscal years 1982–93; fiscal year 1995 President's Budget assumptions shown for fiscal years 1994–95.⁶ Estimated based on historical data and fiscal year 1995 President's Budget assumptions; estimates for fiscal years 1989 and 1990 include the effect of provisions of the Medicare Catastrophic Coverage Act of 1988.⁷ Not available from this office.

Source: Health Care Financing Administration, Office of the Actuary, Office of Medicare and Medicaid Cost Estimates.

TABLE D-18.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX (Taylor, TX) .....	.8830
Aguadilla, PR (Aguada, PR, Aguadilla, PR, Moca, PR) .....	.5525
Akron, OH (Portage, OH, Summit, OH) .....	.8122
Albany, GA (Dougherty, GA, Lee, GA) .....	.8493
Albany-Schenectady-Troy, NY (Albany, NY, Montgomery, NY, Rensselaer, NY, Saratoga, NY, Schenectady, NY, Schoharie, NY) .....	.9033
Albuquerque, NM (Bernalillo, NM, Sandoval, NM, Valencia, NM) .....	.9861
Alexandria, LA (Rapides, LA) .....	.9130
Allentown-Bethlehem-Easton, PA (Carbon, PA, Lehigh, PA, Northampton, PA) .....	.9973
Altونا, PA (Blair, PA) .....	.9342
Amarillo, TX (Potter, TX, Randall, TX) .....	.8667
Anchorage, AK (Anchorage, AK)	1.2201
Ann Arbor, MI (Lenawee, MI, Livingston, MI, Washtenaw, MI)	1.2539
Anniston, AL (Calhoun, AL) .....	.7998
Appleton-Oshkosh-Neenah, WI (Calumet, WI, Outagamie, WI, Winnebago, WI) .....	.8743
Arecibo, PR (Arecibo, PR, Camuy, PR, Hatillo, PR) .....	.3705
Asheville, NC (Buncombe, NC, Madison, NC) .....	.9175
Athens, GA (Clarke, GA, Madison, GA, Oconee, GA) .....	.8324
Atlanta, GA (Barrow, GA, Bartow, GA, Carroll, GA, Cherokee, GA, Clayton, GA, Cobb, GA, Coweta, GA, De Kalb, GA, Douglas, GA, Fayette, GA, Forsyth, GA, Fulton, GA, Gwinnett, GA, Henry, GA, Newton, GA, Paulding, GA, Pickens, GA, Rockdale, GA, Spalding, GA, Walton, GA) .....	.9402
Atlantic City-Cape May, NJ (Atlantic City, NJ, Cape May, NJ)	1.0584
Augusta-Aiken, GA-SC (Columbia, GA, McDuffie, GA, Richmond, GA, Aiken, SC, Edgefield SC) .....	.8899
Austin-San Marcos, TX (Bastrop, TX, Caldwell, TX, Hays, TX, Travis, TX, Williamson, TX) .....	.9209
Bakersfield, CA (Kern, CA)	1.0857
Baltimore, MD (Anne Arundel, MD, Baltimore, MD, Baltimore City, MD, Car- roll, MD, Harford, MD, Howard, MD, Queen Annes, MD)	1.0036
Bangor, ME (Penobscot, ME) .....	.9191
Barnstable-Yarmouth, MA (Barnstable, MA)	1.3351
Baton Rouge, LA (Ascension, LA, East Baton Rouge, LA, Livingston, LA, West Baton Rouge, LA) .....	.8659
Beaumont-Port Arthur, TX (Hardin, TX, Jefferson, TX, Orange, TX) .....	.8934
Bellingham, WA (Whatcom, WA)	1.1147
Benton Harbor, MI (Berrien, MI) .....	.7923
Bergen-Passaic, NJ (Bergen, NJ, Passaic, NJ)	1.1331
Billings, MT (Yellowstone, MT) .....	.8992
Biloxi-Gulfport-Pascagoula, MS (Hancock, MS, Harrison, MS, Jackson, MS) .	.8056
Binghamton, NY (Broome, NY, Tioga, NY) .....	.9098
Birmingham, AL (Blount, AL, Jefferson, AL, Saint Clair, AL, Shelby, AL) .....	.9006
Bismarck, ND (Burleigh, ND, Morton, ND) .....	.8759
Bloomington, IN (Monroe, IN) .....	.8525
Bloomington-Normal, IL (McLean, IL) .....	.8566
Boise City, ID (Ada, ID, Canyon, ID) .....	.8883

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Boston-Brockton-Nashua, MA—HN (Bristol, MA, Essex, MA, Middlesex, MA, Norfolk, MA, Plymouth, MA, Suffolk, MA, Worcester, MA, Hillsborough, NH, Merrimack, NH, Rockingham, NH, Strafford, NH)	1.1503
Boulder-Longmont, CO (Boulder, CO) .....	.8197
Brazoria, TX (Brazoria, TX) .....	.8655
Bremerton, WA (Kitsap, WA) .....	.9529
Brownsville-Harlingen-San Benito, TX (Cameron, TX) .....	.8479
Bryan-College Station, TX (Brazos, TX) .....	.9054
Buffalo-Niagara Falls, NY (Erie, NY, Niagara, NY) .....	.9117
Burlington, VT (Chittenden, VT, Franklin, VT, Grand Isle, VT) .....	.9458
Caguas, PR (Caguas, PR, Cayey, PR, Cidra, PR, Gurabo, PR, San Lorenzo, PR) .....	.5039
Canton, OH (Carroll, OH, Stark, OH) .....	.8718
Casper, WY (Natrona, WY) .....	.8408
Cedar Rapids, IA (Linn, IA) .....	.8475
Champaign-Urbana, IL (Champaign, IL) .....	.8720
Charleston-North Charleston, SC (Berkeley, SC, Charleston, SC, Dorchester, SC) .....	.8947
Charleston, WV (Kanawha, WV, Putnam, WV) .....	.8786
Charlotte-Gastonia-Rock Hill, NC—SC (Cabarrus, NC, Gaston, NC, Lincoln, NC, Mecklenburg, NC, Rowan, NC, Union, NC, York, SC) .....	.9648
Charlottesville, VA (Albermale, VA, Charlottesville City, VA, Fluvanna, VA, Greene, VA) .....	.9477
Chattanooga, TN—GA (Catoosa, GA, Dade, GA, Walker, GA, Hamilton, TN, Marion, TN) .....	.9088
Cheyenne, WY (Laramie, WY) .....	.7538
Chicago, IL (Cook, IL, De Kalb, IL, Du Page, IL, Grundy, IL, Kane, IL, Kendall, IL, Lake, IL, McHenry, IL)	1.0593
Chico-Paradise, CA (Butte, CA)	1.0071
Cincinnati, OH—KY—IN (Dearborn, IN, Boone, KY, Campbell, KY, Gallatin, KY, Grant, KY, Kenton, KY, Pendleton, KY, Brown, OH, Clermont, OH, Hamilton, OH, Warren, OH) .....	.9548
Clarksville-Hopkinsville, TN—KY (Christian, KY, Montgomery, TN) .....	.6826
Cleveland-Lorain-Elyria, OH (Ashtabula, OH, Cuyahoga, OH, Geauga, OH, Lake, OH, Lorain, OH, Medina, OH) .....	.9817
Colorado Springs, CO (El Paso, CO) .....	.9464
Columbia, MO (Boone, MO) .....	.9312
Columbia, SC (Lexington, SC, Richland, SC) .....	.8851
Columbus, GA—AL (Russell, AL, Chattahoochee, GA, Muscogee, GA) .....	.7562
Columbus, OH (Delaware, OH, Fairfield, OH, Franklin, OH, Licking, OH, Madison, OH, Pickaway, OH, Union, OH) .....	.9902
Corpus Christi, TX (Nueces, TX, San Patricio, TX) .....	.8334
Cumberland, MD—WV (Allegheny, MD, Mineral, WV) .....	.8103
Dallas, TX (Collin, TX, Dallas, TX, Denton, TX, Ellis, TX, Henderson, TX, Hunt, TX, Kaufman, TX, Rockwall, TX) .....	.9649
Danville, VA (Danville City, VA, Pittsylvania, VA) .....	.7881
Davenport-Rock Island-Moline, IA—IL (Scott, IA, Henry, IL, Rock Island, IL) .....	.8300
Dayton-Springfield, OH (Clark, OH, Greene, OH, Miami, OH, Montgomery, OH) .....	.9424
Daytona Beach, FL (Volusia, FL) .....	.8826

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Decatur, AL (Lawrence, AL, Morgan, AL) .....	.7995
Decatur, IL (Macon, IL) .....	.8011
Denver, CO (Adams, CO, Arapahoe, CO, Denver, CO, Douglas, CO, Jefferson, CO)	1.0935
Des Moines, IA (Dallas, IA, Polk, IA, Warren, IA) .....	.8676
Detroit, MI (Lapeer, MI, Macomb, MI, Monroe, MI, Oakland, MI, Saint Clair, MI, Wayne, MI)	1.0790
Dothan, AL (Dale, AL, Houston, AL) .....	.7793
Dover, DE (Kent, DE) .....	.8728
Dubuque, IA (Dubuque, IA) .....	.8324
Duluth-Superior, MN-WI (St. Louis, MN, Douglas, WI) .....	.9166
Dutchess County, NY (Dutchess, NY)	1.0623
Eau Claire, WI (Chippewa, WI, Eau Claire, WI) .....	.8481
El Paso, TX (El Paso, TX) .....	.9537
Elkhart-Goshen, IN (Elkhart, IN) .....	.8560
Elmira, NY (Chemung, NY) .....	.8558
Enid, OK (Garfield, OK) .....	.7985
Erie, PA (Erie, PA) .....	.9169
Eugene-Springfield, OR (Lane, OR) .....	.9480
Evansville, IN-KY (Posey, IN, Vanderburgh, IN, Warrick, IN, Henderson, KY) .....	.8904
Fargo-Moorhead, ND-MN (Clay, MN, Cass, ND) .....	.9557
Fayetteville, NC (Cumberland, NC) .....	.8519
Fayetteville-Springdale-Rogers, AR (Benton, AR, Washington, AR) .....	.7247
Flint, MI (Genesee, MI)	1.0689
Florence, AL (Colbert, AL, Lauderdale, AL) .....	.7707
Florence, SC (Florence, SC) .....	.8671
Fort Collins-Loveland, CO (Larimer, CO) .....	.9885
Fort Lauderdale, FL (Broward, FL)	1.0573
Fort Myers-Cape Coral, FL (Lee, FL) .....	.9279
Fort Pierce-Port St. Lucie, FL (Martin, FL, St. Lucie, FL)	1.0477
Fort Smith, AR-OK (Crawford, AR, Sebastian, AR, Sequoyah, OK) .....	.7611
Fort Walton Beach, FL (Okaloosa, FL) .....	.8825
Fort Wayne, IN (Adams, IN, Allen, IN, De Kalb, IN, Huntington, IN, Wells, IN, Whitley, IN) .....	.8893
Fort Worth-Arlington, TX (Johnson, TX, Parker, TX, Tarrant, TX) .....	.9550
Fresno, CA (Fresno, CA, Madera, CA)	1.0244
Gadsden, AL (Etowah, AL) .....	.7747
Gainesville, FL (Alachua, FL) .....	.8911
Galveston-Texas City, TX (Galveston, TX) .....	.9865
Gary, IN (Lake, IN, Porter, IN) .....	.8740
Glens Falls, NY (Warren, NY, Washington, NY) .....	.9393
Goldsboro, NC (Wayne, NC) .....	.8399
Grand Forks, ND-MN (Polk, MN, Grand Forks, ND) .....	.8795
Grand Rapids-Muskegon-Holland, MI (Allegan, MI, Kent, MI, Muskegon, MI, Ottawa, MI) .....	.9764
Great Falls, MT (Cascade, MT) .....	.8906
Greeley, CO (Weld, CO) .....	.8714
Green Bay, WI (Brown, WI) .....	.8852

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Greensboro-Winston-Salem-High Point, NC (Alamance, NC, Davidson, NC, Davie, NC, Forsyth, NC, Guilford, NC, Randolph, NC, Stokes, NC, Yadkin, NC) .....	.9283
Greenville, NC (Pitt, NC) .....	.9331
Greenville-Spartanburg-Anderson, SC (Anderson, SC, Cherokee, SC, Greenville, SC, Pickens, SC, Spartanburg, SC) .....	.8715
Hagerstown, MD (Washington, MD) .....	.8830
Hamilton-Middletown, OH (Butler, OH) .....	.8122
Harrisburg-Lebanon-Carlisle, PA (Cumberland, PA, Dauphin, PA, Lebanon, PA, Perry, PA) .....	.9995
Hartford, CT (Hartford, CT, Litchfield, CT, Middlesex, CT, Tolland, CT)	1.2086
Hickory-Morganton, NC (Alexander, NC, Burke, NC, Caldwell, NC, Catawba, NC) .....	.8800
Honolulu, HI (Honolulu, HI)	1.0995
Houma, LA (Lafourche, LA, Terrebonne, LA) .....	.7765
Houston, TX (Chambers, TX, Fort Bend, TX, Harris, TX, Liberty, TX, Montgomery, TX, Waller, TX) .....	.9908
Huntington-Ashland, WV-KY-OH (Boyd, KY, Carter, KY, Greenup, KY, Lawrence, OH, Cabell, WV, Wayne, WV) .....	.8971
Huntsville, AL (Limestone, AL, Madison, AL) .....	.8158
Indianapolis, IN (Boone, IN, Hamilton, IN, Hancock, IN, Hendricks, IN, Johnson, IN, Marion, IN, Morgan, IN, Shelby, IN) .....	.9871
Iowa City, IA (Johnson, IA) .....	.9706
Jackson, MI (Jackson, MI) .....	.9277
Jackson, MS (Hinds, MS, Madison, MS, Rankin, MS) .....	.7519
Jackson, TN (Madison, TN) .....	.8007
Jacksonville, FL (Clay, FL, Duval, FL, Nassau, FL, St. Johns, FL) .....	.8968
Jacksonville, NC (Onslow, NC) .....	.7197
Jamestown, NY (Chautauqua, NY) .....	.7688
Janesville-Beloit, WI (Rock, WI) .....	.8415
Jersey City, NJ (Hudson, NJ)	1.0966
Johnson City-Kingsport-Bristol, TN-VA (Carter, TN, Hawkins, TN, Sullivan, TN, Unicoi, TN, Washington, TN, Bristol City, VA, Scott, VA, Washington, VA) .....	.8472
Johnstown, PA (Cambria, PA, Somerset, PA) .....	.8786
Joplin, MO (Jasper, MO, Newton, MO) .....	.7697
Kalamazoo-Battlecreek, MI (Calhoun, MI, Kalamazoo, MI, Van Buren, MI)	1.0945
Kankakee, IL (Kankakee, IL) .....	.8458
Kansas City, KS-MO (Johnson, KS, Leavenworth, KS, Miami, KS, Wyandotte, KS, Cass, MO, Clay, MO, Clinton, MO, Jackson, MO, Lafayette, MO, Platte, MO, Ray, MO) .....	.9538
Kenosha, WI (Kenosha, WI) .....	.8846
Killeen-Temple, TX (Bell, TX, Coryell, TX)	1.0169
Knoxville, TN (Anderson, TN, Blount, TN, Knox, TN, Loudon, TN, Sevier, TN, Union, TN) .....	.9247
Kokomo, IN (Howard, IN, Tipton, IN) .....	.8616
LaCrosse, WI-MN (Houston, MN, La Crosse, WI) .....	.8409
Lafayette, LA (Arcadia, LA, Lafayette, LA, St. Landry, LA, St. Martin, LA) ..	.8144
Lafayette, IN (Clinton, IN, Tippecanoe, IN) .....	.8415
Lake Charles, LA (Calcasieu, LA) .....	.8134

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Lakeland-Winter Haven, FL (Polk, FL) .....	.8335
Lancaster, PA (Lancaster, PA) .....	.9520
Lansing-East Lansing, MI (Clinton, MI, Eaton, MI, Ingham, MI) .....	.9633
Laredo, TX (Webb, TX) .....	.6953
Las Cruces, NM (Dona Ana, NM) .....	.8919
Las Vegas, NV-AZ (Mohave, AZ, Clark, NV, Nye, NV)	1.0714
Lawrence, KS (Douglas, KS) .....	.8793
Lawton, OK (Comanche, OK) .....	.8453
Lewiston-Auburn, ME (Androscoggin, ME) .....	.9644
Lexington, KY (Bourbon, KY, Clark, KY, Fayette, KY, Jessamine, KY, Madison, KY, Scott, KY, Woodford, KY) .....	.8291
Lima, OH (Allen, OH, Auglaize, OH) .....	.8441
Lincoln, NE (Lancaster, NE) .....	.8904
Little Rock-North Little Rock, AR (Faulkner, AR, Lonoke, AR, Pulaski, AR, Saline, AR) .....	.8306
Longview-Marshall, TX (Gregg, TX, Harrison, TX, Upshur, TX) .....	.8720
Los Angeles-Long Beach, CA (Los Angeles, CA)	1.2719
Louisville, KY-IN (Clark, IN, Floyd, IN, Harrison, IN, Scott, IN, Bullitt, KY, Jefferson, KY, Oldham, KY) .....	.9407
Lubbock, TX (Lubbock, TX) .....	.8678
Lynchburg, VA (Amherst, VA, Bedford City, VA, Bedford, VA, Campbell, VA, Lynchburg City, VA) .....	.8226
Macon, GA (Bibb, GA, Houston, GA, Jones, GA, Peach, GA, Twiggs, GA) .....	.9704
Madison, WI (Dane, WI) .....	.9977
Mansfield, OH (Crawford, OH, Richland, OH) .....	.8158
Mayaguez, PR (Anasco, PR, Cabo Rojo, PR, Hormigueros, PR, Mayaguez, PR, Sabana Grande, PR, San German, PR) .....	.5397
McAllen-Edinburg-Mission, TX (Hidalgo, TX) .....	.8497
Medford-Ashland, OR (Jackson, OR) .....	.9768
Melbourne-Titusville, FL (Brevard, FL) .....	.9356
Memphis, TN-AR-MS (Crittenden, AR, De Soto, MS, Fayette, TN, Shelby, TN, Tipton, TN) .....	.8546
Merced, CA (Merced, CA)	1.0021
Miami, FL (Dade, FL) .....	.8515
Middlesex-Somerset-Hunterdon, NJ (Hunterdon, NJ, Middlesex, NJ, Somerset, NJ)	1.0871
Milwaukee, WI (Milwaukee, WI, Ozaukee, WI, Washington, WI, Waukesha, WI) .....	.9240
Minneapolis-St. Paul, MN-WI (Anoka, MN, Carver, MN, Chisago, MN, Dakota, MN, Hennepin, MN, Isanti, MN, Ramsey, MN, Scott, MN, Sherburne, MN, Washington, MN, Wright, MN, Pierce, WI, St. Croix, WI)	1.0855
Mobile, AL (Baldwin, AL, Mobile, AL) .....	.7801
Modesto, CA (Stanislaus, CA)	1.1471
Monmouth-Ocean, NJ (Monmouth, NJ, Ocean, NJ)	1.0082
Monroe, LA (Ouachita, LA) .....	.7663
Montgomery, AL (Autauga, AL, Elmore, AL, Montgomery, AL) .....	.7564
Muncie, IN (Delaware, IN) .....	.8456
Myrtle Beach, SC (Horry, SC) .....	.7906
Naples, FL (Collier, FL) .....	.9646

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Nashville, TN (Cheatham, TN, Davidson, TN, Dickson, TN, Robertson, TN, Rutherford, TN, Sumner, TN, Williamson, TN, Wilson, TN) .....	.9105
Nassau-Suffolk, NY (Nassau, NY, Suffolk, NY)	1.2855
New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT (Fairfield, CT, New Haven, CT)	1.2289
New London-Norwich, CT (New London, CT)	1.1589
New Orleans, LA (Jefferson, LA, Orleans, LA, St. Bernard, LA, St. Charles, LA, St. James, LA, St. John The Baptist, LA, St. Tammany, LA) .....	.9443
New York, NY (Bronx, NY, Kings, NY, New York, NY, Putnam, NY, Queens, NY, Richmond, NY, Rockland, NY, Westchester, NY)	1.4020
Newark, NJ (Essex, NJ, Morris, NJ, Sussex, NJ, Union, NJ)	1.1145
Newburgh, NY-PA (Orange, NY, Pike, PA) .....	.8560
Norfolk-Virginia Beach-Newport News, VA-NC (Currituck, NC, Chesapeake City, VA, Gloucester, VA, Hampton City, VA, Isle of Wight, VA, James City, VA, Matthews, VA, Newport News City, VA, Norfolk City, VA, Poquoson City, VA, Portsmouth City, VA, Suffolk City, VA, Virginia Beach City, VA, Williamsburg City, VA, York, VA) .....	.8541
Oakland, CA (Alameda, CA, Contra Costa, CA)	1.4369
Ocala, FL (Marion, FL) .....	.8490
Odessa-Midland, TX (Ector, TX, Midland, TX) .....	.8735
Oklahoma City, OK (Canadian, OK, Cleveland, OK, Logan, OK, McClain, OK, Oklahoma, OK, Pottawatomie, OK) .....	.8455
Olympia, WA (Thurston, WA)	1.0326
Omaha, NE-IA (Pottawattamie, IA, Cass, NE, Douglas, NE, Sarpy, NE, Washington, NE) .....	.9900
Orange County, NY (Orange, NY)	1.3409
Orlando, FL (Lake, FL, Orange, FL, Osceola, FL, Seminole, FL) .....	.9782
Owensboro, KY (Daviess, KY) .....	.7654
Panama City, FL (Bay, FL) .....	.8359
Parkersburg-Marietta, WV-OH (Washington, OH, Wood, WV) .....	.7748
Pensacola, FL (Escambia, FL, Santa Rosa, FL) .....	.8429
Peoria-Pekin, IL (Peoria, IL, Tazewell, IL, Woodford, IL) .....	.8706
Philadelphia, PA-NJ (Burlington, NJ, Camden, NJ, Gloucester, NJ, Salem, NJ, Bucks, PA, Chester, PA, Delaware, PA, Montgomery, PA, Philadelphia, PA)	1.1254
Phoenix-Mesa, AZ (Maricopa, AZ, Pinal, AZ)	1.0223
Pine Bluff, AR (Jefferson, AR) .....	.8714
Pittsburgh, PA (Allegheny, PA, Fayette, PA, Washington, PA, Westmoreland, PA) .....	.9950
Pittsfield, MA (Berkshire, MA)	1.1001
Ponce, PR (Guayanilla, PR, Juana Diaz, PR, Penuelas, PR, Ponce, PR, Villalba, PR, Yauco, PR) .....	.5167
Portland, ME (Cumberland, ME, Sagadahoc, ME, York, ME) .....	.9381
Portland-Vancouver, OR-WA (Clackamas, OR, Columbia, OR, Multnomah, OR, Washington, OR, Yamhill, OR, Clark, WA)	1.1051
Providence-Warwick, RI (Bristol, RI, Kent, RI, Newport, RI, Providence, RI, Washington, RI)	1.0717
Provo-Orem, UT (Utah, UT) .....	.9960
Pueblo, CO (Pueblo, CO) .....	.8260
Punta Gorda, FL (Charlotte, FL) .....	.9133

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Racine, WI (Racine, WI) .....	.8298
Raleigh-Durham-Chapel Hill, NC (Chatham, NC, Durham, NC, Franklin, NC, Johnston, NC, Orange, NC, Wake, NC) .....	.9521
Rapid City, SD (Pennington, SD) .....	.8220
Reading, PA (Berks, PA) .....	.9082
Redding, CA (Shasta, CA)	1.1622
Reno, NV (Washoe, NV)	1.2009
Richland-Kennewick-Pasco, WA (Benton, WA, Franklin, WA) .....	.9214
Richmond-Petersburg, VA (Charles City Co., VA, Chesterfield, VA, Colonial Heights City, VA, Dinwiddie, VA, Goochland, VA, Hanover, VA, Henrico, VA, Hopewell City, VA, New Kent, VA, Petersburg City, VA, Powhatan, VA, Prince George, VA, Richmond City, VA) .....	.8801
Riverside-San Bernardino, CA (Riverside, CA, San Bernardino, CA)	1.2021
Roanoke, VA (Botetourt, VA, Roanoke, VA, Roanoke City, VA, Salem City, VA) .....	.8358
Rochester, MN (Olmsted, MN)	1.0078
Rochester, NY (Genesee, NY, Livingston, NY, Monroe, NY, Ontario, NY, Orleans, NY, Wayne, NY) .....	.9761
Rockford, IL (Boone, IL, Winnebago, IL) .....	.8708
Rocky Mount, NC (Edgecombe, NC, Nash, NC) .....	.8743
Sacramento, CA (El Dorado, CA, Placer, CA, Sacramento, CA)	1.2165
Saginaw-Bay City-Midland, MI (Bay, MI, Midland, MI, Saginaw, MI) .....	.9549
St. Cloud, MN (Benton, MN, Stearns, MN) .....	.9825
St. Joseph, MO (Andrews, MO, Buchanan, MO) .....	.8811
St. Louis, MO—IL (Clinton, IL, Jersey, IL, Madison, IL, Monroe, IL, St. Clair, IL, Franklin, MO, Jefferson, MO, Lincoln, MO, St. Charles, MO, St. Louis, MO, St. Louis City, MO, Warren, MO) .....	.9182
Salem, OR (Marion, OR, Polk, OR) .....	.9443
Salinas, CA (Monterey, CA)	1.3187
Salt Lake City-Ogden, UT (Davis, UT, Salt Lake, UT, Weber, UT) .....	.9669
San Angelo, TX (Tom Green, TX) .....	.7887
San Antonio, TX (Bexar, TX, Comal, TX, Guadalupe, TX, Wilson, TX) .....	.8210
San Diego, CA (San Diego, CA)	1.2040
San Francisco, CA (Marin, CA, San Francisco, CA, San Mateo, CA)	1.4086
San Jose, CA (Santa Clara, CA)	1.4254
San Juan-Bayamon, PR (Aguas Buenas, PR, Barceloneta, PR, Bayamon, PR, Canovanas, PR, Carolina, PR, Catano, PR, Ceiba, PR, Comerio, PR, Corozal, PR, Dorado, PR, Fajardo, PR, Florida, PR, Guaynabo, PR, Humacao, PR, Juncos, PR, Los Piedras, PR, Loiza, PR, Luguillo, PR, Manati, PR, Naranjito, PR, Rio Grande, PR, San Juan, PR, Toa Alta, PR, Toa Baja, PR, Trujillo Alto, PR, Vega Alta, PR, Vega Baja, PR, Yabucoa, PR) .....	.4969
San Luis Obispo-Atascadero-Pasa Robles, CA (San Luis Obispo, CA)	1.2505
Santa Barbara-Santa Maria-Lompoc, CA, Santa Barbara, CA)	1.1637
Santa Cruz-Watsonville, CA (Santa Cruz, CA) .....	.9727
Santa Fe, NM (Los Alamos, NM, Santa Fe, NM) .....	.9985
Santa Rosa, CA (Sonoma, CA)	1.3084
Sarasota-Bradenton, FL (Manatee, FL, Sarasota, FL) .....	.9712
Savannah, GA (Bryan, GA, Chatham, GA, Effingham, GA) .....	.8675

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Scranton-Wilkes Barre-Hazleton, PA (Columbia, PA, Lackawanna, PA, Luzerne, PA, Wyoming, PA) .....	.8605
Seattle-Bellevue-Everett, WA (Island, WA, King, WA, Snohomish, WA)	1.0985
Sharon, PA (Mercer, PA) .....	.8885
Sheboygan, WI (Sheboygan, WI) .....	.8229
Sherman-Denison, TX (Grayson, TX) .....	.8912
Shreveport-Bossier City, LA (Bossier, LA, Caddo, LA, Webster, LA) .....	.8967
Sioux City, IA—NE (Woodbury, IA, Dakota, NE) .....	.8537
Sioux Falls, SD (Lincoln, SD, Minnehaha, SD) .....	.8719
South Bend, IN (St. Joseph, IN) .....	.9486
Spokane, WA (Spokane, WA)	1.0170
Springfield, IL (Menard, IL, Sangamon, IL) .....	.8727
Springfield, MO (Christian, MO, Greene, MO, Webster, MO) .....	.7866
Springfield, MA (Hampden, MA, Hampshire, MA)	1.0320
State College, PA (Centre, PA) .....	.9446
Steubenville-Weirton, OH—WV (Jefferson, OH, Brooke, WV, Hancock, WV) .....	.8013
Stockton-Lodi, CA (San Joaquin, CA)	1.1147
Sumter, SC (Sumter, SC) .....	.7691
Syracuse, NY (Cayuga, NY, Madison, NY, Onondaga, NY, Oswego, NY) .....	.9869
Tacoma, WA (Pierce, WA)	1.0165
Tallahassee, FL (Gadsden, FL, Leon, FL) .....	.8339
Tampa-St. Petersburg-Clearwater, FL (Hernando, FL, Hillsborough, FL, Pasco, FL, Pinellas, FL) .....	.9351
Terre Haute, IN (Clay, IN, Vermillion, IN, Vigo, IN) .....	.8599
Texarkana, OK-Texarkana, TX (Miller, AR, Bowie, TX) .....	.8085
Toledo, OH (Fulton, OH, Lucas, OH, Wood, OH) .....	.9970
Topeka, KS (Shawnee, KS) .....	.9211
Trenton, NJ (Mercer, NJ)	1.0103
Tucson, AZ (Pima, AZ) .....	.9843
Tulsa, OK (Creek, OK, Osage, OK, Rogers, OK, Tulsa, OK, Wagoner, OK) .....	.8311
Tuscaloosa, AL (Tuscaloosa, AL) .....	.8511
Tyler, TX (Smith, TX) .....	.9119
Utica-Rome, NY (Herkimer, NY, Oneida, NY) .....	.8705
Vallejo-Fairfield-Napa, CA (Napa, CA, Solano, CA)	1.2013
Ventura, CA (Ventura, CA)	1.2161
Victoria, TX (Victoria, TX) .....	.8928
Vineland-Millville-Bridgeton, NJ (Cumberland, NJ)	1.0046
Visalia-Tulare-Porterville, CA (Tulare, CA)	1.0667
Waco, TX (McLennan, TX) .....	.7748
Washington, DC—MD—VA—WV (District of Columbia, DC, Calvert, MD, Charles, MD, Frederick, MD, Montgomery, MD, Prince Georges, MD, Alexandria City, VA, Arlington, VA, Clarke, VA, Culpepper, VA, Fairfax, VA, Fairfax City, VA, Falls Church City, VA, Fauquier, VA, Fredericksburg City, VA, King George, VA, Loudoun, VA, Manassas City, VA, Manassas Park City, VA, Prince William, VA, Spotsylvania, VA, Stafford, VA, Warren, VA, Berkeley, WV, Jefferson, WV)	1.0828
Waterloo-Cedar Falls, IA (Black Hawk, IA) .....	.8726
Wausau, WI (Marathon, WI) .....	.9774
West Palm Beach-Boca Raton, FL (Palm Beach, FL)	1.0254
Wheeling, OH—WV (Belmont, OH, Marshall, WV, Ohio, WV) .....	.7694

TABLE D-18.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Wichita, KS (Butler, KS, Harvey, KS, Sedgwick, KS) .....	.9777
Wichita Falls, TX (Archer, TX, Wichita, TX) .....	.7951
Williamsport, PA (Lycoming, PA) .....	.8503
Wilmington-Newark, DE-MD (New Castle, DE, Cecil, MD)	1.0667
Wilmington, NC (New Hanover, NC, Brunswick, NC) .....	.9037
Yakima, WA (Yakima, WA) .....	.9421
Yolo, CA (Yolo, CA)	1.1391
York, PA (York, PA) .....	.9075
Youngstown-Warren, OH (Columbiana, OH, Mahoning, OH, Trumbull, OH) ...	.9327
Yuba City, CA (Sutter, CA, Yuba, CA)	1.0585
Yuma, AZ .....	.9617

Source: Federal Register, September 1, 1993.

TABLE D-19.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index	Nonurban area	Wage index
Alabama	0.6935	New Hampshire	0.9684
Alaska	1.2939	New Jersey	(N/A)
Arizona	0.8488	New Mexico	0.7480
Arkansas	0.6871	New York	0.8560
California	0.9727	North Carolina	0.7804
Colorado	0.8197	North Dakota	0.7204
Connecticut	1.2545	Ohio	0.8122
Delaware	0.8359	Oklahoma	0.6884
Florida	0.8515	Oregon	0.9176
Georgia	0.7573	Pennsylvania	0.8786
Hawaii	1.0841	Puerto Rico	0.5256
Idaho	0.8471	Rhode Island	(N/A)
Illinois	0.7316	South Carolina	0.7691
Indiana	0.7720	South Dakota	0.6960
Iowa	0.7327	Tennessee	0.7536
Kansas	0.7069	Texas	0.7522
Kentucky	0.7511	Utah	0.9025
Louisiana	0.7118	Vermont	0.8765
Maine	0.8493	Virgin Islands	(N/A)
Maryland	0.8618	Virginia	0.7658
Massachusetts	1.0741	Washington	0.9348
Michigan	0.8616	West Virginia	0.8484
Minnesota	0.8141	Wisconsin	0.8298
Mississippi	0.6657	Wyoming	0.7833
Missouri	0.7331		
Montana	0.8029		
Nebraska	0.7168		
Nevada	0.9324		

N/A = All counties within state are classified urban.

Source: Federal Register, September 1, 1933

TABLE D-20.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to—	Wage index	Area reclassified to—	Wage index
Albany, GA	0.8493	Houston, TX	0.9908
Albany-Schenectady-Troy, NY	0.9033	Huntington-Ashland, WV-KY-OH	0.8817
Albuquerque, NM	0.9861	Huntsville, AL	0.7954
Alexandria, LA	0.9130	Indianapolis, IN	0.9871
Anchorage, AK	1.2201	Jackson, MS	0.7519
Anchorage, AK (Rural Alaska Hospitals)	1.2939	Jackson, TN	0.8007
Atlanta, GA	0.9402	Johnson City-Kingsport-Bristol, TN-VA	0.8472
Augusta-Aiken, GA-SC	0.8899	Joplin, MO	0.7697
Baton Rouge, LA	0.8659	Kalamazoo-Battlecreek, MI	1.0749
Benton Harbor, MI	0.7923	Kansas City, KS-MO	0.9538
Benton Harbor, MI (Rural Michigan Hos- pitals)	0.8616	Kokomo, IN	0.8440
Billings, MT	0.8992	Lafayette, LA	0.8144
Biloxi-Gulfport, MS	0.7807	Lafayette, IN	0.8415
Binghamton, NY	0.8820	Lansing-East Lansing, MI	0.9633
Birmingham, AL	0.9006	Lexington, KY	0.8291
Bismark, ND	0.8475	Lima, OH	0.8441
Boston-Brockton-Nashua, MA-NH	1.1503	Lincoln, NE	0.8469
Brazoria, TX	0.8441	Little Rock-North Little Rock, AK	0.8306
Bryan-College Station, TX	0.8864	Los Angeles-Long Beach, CA	1.2719
Caguas, PR	0.5039	Macon, GA	0.9254
Caguas, PR (Rural Puerto Rico Hospitals)	0.5256	Mansfield, OH	0.8158
Charleston-North Charleston, SC	0.8947	Medford-Ashland, OR	0.9768
Charleston, WV	0.8786	Memphis, TN-AR-MS	0.8341
Charlotte-Gastonia-Rock Hill, NC-SC	0.9648	Miami, FL	0.7704
Chattanooga, TN-GA	0.8929	Miami, FL (Rural Florida Only)	0.8515
Chicago, IL	1.0593	Middlesex-Somerset-Hunterdon, NJ	1.0651
Chico-Paradise, CA	1.0071	Milwaukee, WI	0.9240
Cincinnati, OH-KY-IN	0.9548	Minneapolis-St. Paul, MN-WI	1.0855
Cleveland-Lorain-Elyria, OH	0.9688	Modesto, CA	1.1471
Columbia, MO	0.8967	Monroe, LA	0.7663
Columbus, OH	0.9902	Montgomery, AL	0.7564
Dallas, TX	0.9649	Myrtle Beach, SC	0.7906
Davenport-Rock Island-Moline, IA-IL	0.8300	Nashville, TN	0.9105
Dayton-Springfield, OH	0.9424	New Haven-Bridgeport-Sramford-Danbury- Waterbury, CT	1.2289
Denver, CO	1.0821	New London-Norwich, CT	1.1589
Des Moines, IA	0.8676	New Orleans, LA	0.9443
Detroit, MI	1.0790	New York, NY	1.4020
Dothan, AL	0.7793	Newark, NJ	1.1008
Dubuque, IA	0.8324	Newburgh, NY-PA	0.9908
Duluth, Superior, MN-WI	0.9166	Oakland, CA	1.4369
Dutchess County, NY	1.0623	Odessa-Midland, TX	0.8735
Elkhart-Goshen, IN	0.8390	Oklahoma, City, OK	0.8455
Eugene-Springfield, OR	0.9480	Olympia, WA	1.0326
Fargo-Moorhead, ND-MN	0.9111	Omaha, NE-IA	0.9900
Fayetteville, NC	0.8281	Orange County, NY	1.3409
Flint, MI	1.0689	Owensboro, KY	0.7654
Florence, AL	0.7707	Peoria-Pekin, IL	0.8249
Florence, SC	0.8671	Philadelphia, PA-NJ	1.1151
Fort Lauderdale, FL	1.0573	Pittsburgh, PA	0.9786
Fort Pierce-Port St. Lucia, FL	0.9876	Portland-Vancouver, OR-WA	1.1051
Fort Smith, AR	0.7611	Provo-Orem, UT	0.9609
Fort Walton Beach, FL	0.8691	Pueblo, CO	0.8260
Fort Wayne, IN	0.8893	Raleigh-Durham-Chapel Hill, NC	0.9521
Fort Worth-Arlington, TX	0.9550	Reno, NV	1.2009
Fresno, CA	1.0244	Roanoke, VA	0.8358
Gadsden, AL	0.7747	Saginaw-Bay City-Midland, MI	0.9549
Glens Falls, NY	0.9393	St. Cloud, MN	0.9711
Great Falls, MT	0.8906	St. Louis, MO-IL	0.9182
Green Bay, WI	0.8852	Salinas, CA	1.3087
Greenville-Spartanburg-Andersen, SC	0.8715	Salt Lake City-Ogden, UT	0.9669
Harrisburg-Lebanon-Carlise, PA	0.9995	San Francisco, CA	1.4086
Hartford, CT	1.1968	San Juan, PR	0.4969
Honolulu, HI	1.0995	Santa Fe, NM	0.9503

TABLE D-20.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to—	Wage index	Area reclassified to—	Wage index
Santa Rosa, CA	1.2827	Wichita, KS	0.9356
Seattle-Bellevue-Everett, WA	1.0985	Rural Alabama	0.6935
Sherman-Denison, TX	0.8912	Rural Georgia	0.7573
South Bend, IN	0.9305	Rural Kentucky	0.7511
Springfield, IL	0.8727	Rural Kentucky (Rural TN Hospitals)	0.7536
Syracuse, NY	0.9749	Rural Louisiana	0.7118
Tampa-St. Petersburg-Clearwater, FL	0.9351	Rural Michigan	0.8616
Texarkana, TX-Texarkana, AR	0.8085	Rural Minnesota	0.8141
Topeka, KS	0.9221	Rural North Carolina	0.7804
Tucson, AZ	0.9843	Rural South Dakota	0.6960
Tulsa, OK	0.8311	Rural South Dakota (Rural ND Hospitals)	0.7168
Tyler, TX	0.9012	Rural Utah	0.9025
Victoria, TX	0.8659	Rural Virginia	0.7656
Waterloo-Cedar Falls, IA	0.8726	Rural West Virginia	0.7969
Wausau, WI	0.9225		

Source: Federal Register, September 1, 1993

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
1	1	SURG	Craniotomy age >17 except for trauma	3.2324	3.1556	-2.4
2	1	SURG	Craniotomy for trauma age >17	3.1311	3.1381	0.2
3	1	SURG	Craniotomy age 0-17	2.9627	3.0176	1.9
4	1	SURG	Spinal procedures	2.3612	2.3847	1.0
5	1	SURG	Extracranial vascular procedures	1.5504	1.5361	-0.9
6	1	SURG	Carpal tunnel release	0.5437	0.6271	15.3
7	1	SURG	Periph and cranial nerve and other nerv syst proc with CC	2.6363	2.5180	-4.5
8	1	SURG	Periph and cranial nerve and other nerv syst proc w/o CC	0.7944	0.8576	8.0
9	1	MED	Spinal disorders and injuries	1.2786	1.3397	4.8
10	1	MED	Nervous system neoplasms with CC	1.2884	1.2819	-0.5
11	1	MED	Nervous system neoplasms w/o CC	0.7649	0.7691	0.5
12	1	MED	Degenerative nervous system disorders	0.9550	0.9449	-1.1
13	1	MED	Multiple sclerosis and cerebellar ataxia	0.8336	0.8108	-2.7
14	1	MED	Specific cerebrovascular disorders except TIA	1.2160	1.2056	-0.9
15	1	MED	Transient ischemic attack and precerebral occlusions	0.8662	0.6766	-21.9
16	1	MED	Nonspecific cerebrovascular disorders with CC	1.1086	1.1141	0.5
17	1	MED	Nonspecific cerebrovascular disorders w/o CC	0.6424	0.6648	3.5
18	1	MED	Cranial and peripheral nerve disorders with CC	0.9170	0.9202	0.3
19	1	MED	Cranial and peripheral nerve disorders w/o CC	0.5958	0.5927	-0.5
20	1	MED	Nervous system infection except viral meningitis	2.0042	2.0613	2.8
21	1	MED	Viral meningitis	1.4505	1.4304	-1.4
22	1	MED	Hypertensive encephalopathy	0.7261	0.7286	0.3
23	1	MED	Nontraumatic stupor and coma	0.8202	0.8407	2.5
24	1	MED	Seizure and headache age >17 with CC	0.9714	0.9759	0.5
25	1	MED	Seizure and headache age >17 w/o CC	0.5282	0.5426	2.7
26	1	MED	Seizure and headache age 0-17	1.0516	0.9878	-6.1

27	1	MED	Traumatic stupor and coma, coma >1 HR	1.3744	1.3311	-3.2
28	1	MED	Traumatic stupor and coma, coma <1 HR age >17 with CC	1.2208	1.2078	-1.1
29	1	MED	Traumatic stupor and coma, coma <1 HR age >17 w/o CC	0.5885	0.5941	1.0
30	1	MED	Traumatic stupor and coma, coma <1 HR age 0-17	0.3593	0.3660	1.9
31	1	MED	Concussion age >17 with CC	0.7707	0.7335	-4.8
32	1	MED	Concussion age >17 w/o CC	0.4454	0.4494	0.9
33	1	MED	Concussion age 0-17	0.2494	0.2540	1.8
34	1	MED	Other disorders of nervous system with CC	1.1442	1.1103	-3.0
35	1	MED	Other disorders of nervous system w/o CC	0.5590	0.5656	1.2
36	2	SURG	Retinal procedures	0.6238	0.6087	-2.4
37	2	SURG	Orbital procedures	0.7883	0.7843	-0.5
38	2	SURG	Primary iris procedures	0.3584	0.3716	3.7
39	2	SURG	Lens procedures with or without vitrectomy	0.4858	0.4723	-2.8
40	2	SURG	Extraocular procedures except orbit age >17	0.5150	0.5586	8.5
41	2	SURG	Extraocular procedures except orbit age 0-17	0.3713	0.3782	1.9
42	2	SURG	Intraocular procedures retina, iris and lens	0.5968	0.5777	-3.2
43	2	MED	HypHEMA	0.4026	0.3814	-5.3
44	2	MED	Acute major eye infections	0.5767	0.5949	3.2
45	2	MED	Neurological eye disorders	0.5989	0.6047	1.0
46	2	MED	Other disorders of the eye age >17 w CC	0.7217	0.7288	1.0
47	2	MED	Other disorders of the eye age >17 w/o CC	0.4156	0.4047	-2.6
48	s	MED	Other disorders of the eye age 0-17	0.4079	0.4155	1.9
49	3	SURG	Major head and neck procedures	1.6029	1.7937	11.9
50	3	SURG	Sialoadenectomy	0.6594	0.6732	2.1
51	3	SURG	Salivary gland procedures except sialoadenectomy	0.6278	0.6515	3.8
52	3	SURG	Cleft lip and palate repair	0.7859	0.7697	-2.1
53	3	SURG	Sinus and mastoid procedures age >17	0.7237	0.7645	5.6
54	3	SURG	Sinus and mastoid procedures age 0-17	0.6994	0.7124	1.9
55	3	SURG	Miscellaneous ear, nose, mouth and throat procedures	0.5469	0.5761	5.3
56	3	SURG	Rhinoplasty	0.6168	0.6412	4.0
57	3	SURG	T and A proc, except tonsillectomy and/or adenoidectomy only, age >17.	0.8845	0.9116	3.1

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
58	3	SURG	T and A, except tonsillectomy and/or adenoidectomy only, age 0-17	0.3145	0.3203	1.8
59	3	SURG	Tonsillectomy and/or adenoidectomy only, age 17	0.4273	0.4158	-2.7
60	3	SURG	Tonsillectomy and/or adenoidectomy only, age 0-17	0.2655	0.2704	1.8
61	3	SURG	Myringotomy w tube insertion age -17	0.8613	1.10307	19.7
62	3	SURG	Myringotomy w tube insertion age 0-17	0.3136	0.3194	1.8
63	3	SURG	Other ear, nose, mouth and throat O.R. procedures	1.0429	1.0520	0.9
64	3	MED	Ear, nose, mouth and throat malignancy	1.1039	1.1571	4.8
65	3	MED	Dyssequilibrium	0.4922	0.4952	0.6
66	3	MED	Epistaxis	0.4885	0.4909	0.5
67	3	MED	Epiglottitis	0.8424	0.8481	0.7
68	3	MED	Otitis media and Uri age >17 with CC	0.7216	0.7158	-0.8
69	3	MED	Otitis media and Uri age >17 w/o CC	0.5000	0.5126	2.5
70	3	MED	Otitis media and Uri age 0-17	0.6126	0.3978	-35.1
71	3	MED	Laryngotracheitis	0.7664	0.6838	-10.8
72	3	MED	Nasal trauma and deformity	0.5844	0.6079	4.0
73	3	MED	Other ear, nose, mouth and throat diagnoses age >17	0.7522	0.7591	0.9
74	3	MED	Other ear, nose, mouth and throat diagnoses age 0-17	0.3480	0.3545	1.9
75	4	SURG	Major chest procedures	3.0400	3.0397	-0.0
76	4	SURG	Other resp system O.R. procedures w CC	2.3973	2.4770	3.3
77	4	SURG	Other resp system O.R. procedures w/o CC	1.0208	1.0443	2.3
78	4	MED	Pulmonary embolism	1.4350	1.4292	-0.4
79	4	MED	Respiratory infections and inflammations age >17 with CC	1.7510	1.7332	-1.0
80	4	MED	Respiratory infections and inflammations age >17 w/o CC	0.9617	0.9278	-3.5
81	4	MED	Respiratory infections and inflammations age 0-17	1.1200	1.1405	1.9
82	4	MED	Respiratory neoplasms	1.2809	1.3105	2.3
83	4	MED	Major chest trauma with CC	0.9490	0.9403	-0.9

84	4	MED	Major chest trauma w/o CC	0.4783	0.4986	4.2
85	4	MED	Pleural effusion with CC	1.1969	1.1891	-0.7
86	4	MED	Pleural effusion w/o CC	0.6711	0.6691	-0.3
87	4	MED	Pulmonary edema and respiratory failure	1.3597	1.3495	-0.8
88	4	MED	Chronic obstructive pulmonary disease	0.9941	1.0067	1.3
89	4	MED	Simple pneumonia and pleurisy age >17 with CC	1.1581	1.1447	-1.2
90	4	MED	Simple pneumonia and pleurisy age >17 w/o CC	0.7090	0.6990	-1.4
91	4	MED	Simple pneumonia and pleurisy age 0-17	0.7985	0.7767	-2.7
92	4	MED	Interstitial lung disease with CC	1.1975	1.2039	0.5
93	4	MED	Interstitial lung disease w/o CC	0.7723	0.7550	-2.2
94	4	MED	Pneumothorax with CC	1.2774	1.2433	-2.7
95	4	MED	Pneumothorax w/o CC	0.5973	0.6067	1.6
96	4	MED	Bronchitis and asthma age >17 with CC	0.9369	0.8776	-6.3
97	4	MED	Bronchitis and asthma age >17 w/o CC	0.6191	0.6067	-2.0
98	4	MED	Bronchitis and asthma age 0-17	0.8924	0.6840	-23.4
99	4	MED	Respiratory signs and symptoms with CC	0.7623	0.7149	-6.2
100	4	MED	Respiratory signs and symptoms w/o CC	0.5049	0.5004	-0.9
101	4	MED	Other respiratory system diagnoses with CC	0.9135	0.9035	-1.1
102	4	MED	Other respiratory system diagnoses w/o CC	0.5426	0.5282	-2.7
103	5	SURG	Heart transplant	12.5568	14.0215	11.7
104	5	SURG	Cardiac valve procedure and with cardiac cath	7.7521	7.6559	-1.2
105	5	SURG	Cardiac valve procedure and w/o cardiac cath	5.8291	5.7990	-0.5
106	5	SURG	Coronary bypass with cardiac cath	5.6583	5.6791	0.4
107	5	SURG	Coronary bypass w/o cardiac cath	4.2348	4.2005	-0.8
108	5	SURG	Other cardiothoracic procedures	5.8725	5.8690	-0.1
109	.....		No longer valid	NV	NV	NV
110	5	SURG	Major cardiovascular procedures with CC	4.0823	4.0494	-0.8
111	5	SURG	Major cardiovascular procedures w/o CC	2.2979	2.3214	1.0
112	5	SURG	Percutaneous cardiovascular procedures	1.9874	1.9736	-0.7
113	5	SURG	Amputation for circ system disorders except upper limb and toe	2.7789	2.7931	0.5
114	5	SURG	Upper limb and toe amputation for circ system disorder	1.5957	1.5631	-2.0

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
115	5	SURG	Perm cardiac pacemaker implant with AMI, heart failure or shock	3.6092	3.5886	-0.6
116	5	SURG	Other perm cardiac pacemaker implant or AICD lead or gen proc	2.4604	2.4248	-1.4
117	5	SURG	Cardiac pacemaker revision except device replacement	1.2264	1.1328	-7.6
118	5	SURG	Cardiac pacemaker device replacement	1.5858	1.5419	-2.8
119	5	SURG	Vein ligation and stripping	0.9650	0.9834	1.9
120	5	SURG	Other circulatory system O.R. procedures	1.9906	1.9626	-1.4
121	5	MED	Circulatory disorders with AMI and C.V. comp disch alive	1.6114	1.6017	-0.6
122	5	MED	Circulatory disorders with AMI w/o C.V. comp disch alive	1.1532	1.1325	-1.8
123	5	MED	Circulatory disorders with AMI, expired	1.4090	1.4116	0.2
124	5	MED	Circulatory disorders except AMI, with card cath and complex diag	1.2029	1.2307	2.3
125	5	MED	Circulatory disorders except AMI, with card cath w/o complex diag	0.7587	0.7960	4.9
126	5	MED	Acute and subacute endocarditis	2.8454	2.7299	-4.1
127	5	MED	Heart failure and shock	1.0150	1.0234	0.8
128	5	MED	Deep vein thrombophlebitis	0.7873	0.7825	-0.6
129	5	MED	Cardiac arrest, unexplained	1.2831	1.1959	-6.8
130	5	MED	Peripheral vascular disorders with CC	0.9106	0.9042	-0.7
131	5	MED	Peripheral vascular disorders w/o CC	0.5861	0.5831	-0.5
132	5	MED	Atherosclerosis with CC	0.7591	0.7594	0.0
133	5	MED	Atherosclerosis w/o CC	0.5312	0.5257	-1.0
134	5	MED	Hypertension	0.5655	0.5614	-0.7
135	5	MED	Cardiac congenital and vascular disorders age >17 with CC	0.8625	0.8609	-0.2
136	5	MED	Cardiac congenital and vascular disorders age >17 w/o CC	0.5266	0.5489	4.2
137	5	MED	Cardiac congenital and vascular disorders age 0-17	0.6411	0.6530	1.9
138	5	MED	Cardiac arrhythmia and conduction disorders with CC	0.8110	0.8038	-0.9
139	5	MED	Cardiac arrhythmia and conduction disorders w/o CC	0.5020	0.4946	-1.5
140	5	MED	Angina pectoris	0.6219	0.6241	0.4
141	5	MED	Syncope and collapse with CC	0.6998	0.7053	0.8

142	5	MED	Syncope and collapse w/o CC	0.5048	0.5150	2.0
143	5	MED	Chest pain	0.5164	0.5189	0.5
144	5	MED	Other circulatory system diagnoses with CC	1.0650	1.0659	0.1
145	5	MED	Other circulatory system diagnoses w/o CC	0.6240	0.6122	-1.9
146	6	SURG	Rectal resection with CC	2.5394	2.4955	-1.7
147	6	SURG	Rectal resection w/o CC	1.5192	1.5328	0.9
148	6	SURG	Major small and large bowel procedures with CC	3.1353	3.1719	1.2
149	6	SURG	Major small and large bowel procedures w/o CC	1.4948	1.5127	1.2
150	6	SURG	Peritoneal adhesiolysis with CC	2.5484	2.5505	0.1
151	6	SURG	Peritoneal adhesiolysis w/o CC	1.1885	1.1738	-1.2
152	6	SURG	Minor small and large bowel procedures with CC	1.7736	1.7955	1.2
153	6	SURG	Minor small and large bowel procedures w/o CC	1.0426	1.0821	3.8
154	6	SURG	Stomach, esophageal and duodenal procedures age >17 with CC	4.0491	4.1338	2.1
155	6	SURG	Stomach, esophageal and duodenal procedures age >17 w/o CC	1.4617	1.3811	-5.5
156	6	SURG	Stomach, esophageal and duodenal procedures age 0-17	0.8510	0.8668	1.9
157	6	SURG	Anal and stomal procedures with CC	0.9575	1.0048	4.9
158	6	SURG	Anal and stomal procedures w/o CC	0.4975	0.5100	2.5
159	6	SURG	Hernia procedures except inguinal and femoral age >17 with CC	1.0747	1.0901	1.4
160	6	SURG	Hernia procedures except inguinal and femoral age >17 w/o CC	0.6168	0.6378	3.4
161	6	SURG	Inguinal and femoral hernia procedures age >17 with CC	0.7820	0.8260	5.6
162	6	SURG	Inguinal and femoral hernia procedures age >17 w/o CC	0.4651	0.4823	3.7
163	6	SURG	Hernia procedures age 0-17	0.4843	0.6795	40.3
164	6	SURG	Appendectomy with complicated principal diag with CC	2.1607	2.1679	0.3
165	6	SURG	Appendectomy with complicated principal diag w/o CC	1.2080	1.2055	-0.2
166	6	SURG	Appendectomy w/o complicated principal diag with CC	1.3251	1.3413	1.2
167	6	SURG	Appendectomy w/o complicated principal dial w/o CC	0.7495	0.7801	4.1
168	3	SURG	Mouth procedures with CC	0.9902	1.0321	4.2
169	3	SURG	Mouth procedures w/o CC	0.5788	0.5824	0.6
170	6	SURG	Other digestive system O.R. procedures with CC	2.7310	2.7524	0.8
171	6	SURG	Other digestive system O.R. procedures w/o CC	1.0898	1.0894	0.0
172	6	MED	Digestive malignancy with CC	1.2990	1.0894	0.0

TABLE D-2.1.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
173	6	MED	Digestive malignancy w/o CC	0.6346	0.6318	-0.4
174	6	MED	G.I. hemorrhage with CC	0.9794	0.9657	-1.4
175	6	MED	G.I. hemorrhage w/o CC	0.5506	0.5354	-2.8
176	6	MED	Complicated peptic ulcer	1.0331	1.0453	1.2
177	6	MED	Uncomplicated peptic ulcer with CC	0.7931	0.7986	0.7
178	6	MED	Uncomplicated peptic ulcer w/o CC	0.5720	0.5804	1.5
179	6	MED	Inflammatory bowel disease	1.1044	1.1072	0.3
180	6	MED	G.I. obstruction with CC	0.9279	0.9180	-1.1
181	6	MED	G.I. obstruction w/o CC	0.5007	0.4969	-0.8
182	6	MED	Esophagitis, gastroent and misc disorders age >17 with CC	0.7721	0.7617	-1.3
183	6	MED	Esophagitis, gastroent and misc digest disorders age >17 w/o CC	0.5296	0.5291	-0.1
184	6	MED	Esophagitis, gastroent and misc digest disorders age 0-17	0.5625	0.4735	-15.8
185	3	MED	Dental and oral dis except extractions and restorations, age >17	0.7854	0.8248	5.0
186	3	MED	Dental and oral dis except extractions and restorationsm age 0-17	0.4174	0.4251	1.8
187	3	MED	Dental extractions and restorations	0.5650	0.5852	3.6
188	6	MED	Other digestive system diagnoses age >17 with CC	0.9971	1.0050	0.8
189	6	MED	Other digestive system diagnoses age >17 w/o CC	0.4804	0.4775	-0.6
190	6	MED	Other digestive system diagnoses age 0-17	0.6796	0.7577	11.5
191	7	SURG	Pancreas, liver and shunt procedures with CC	4.4652	4.3319	-3.0
192	7	MED	Pancreas, liver and shunt procedures w/o CC	1.7051	1.6460	-3.5
193	7	SURG	Biliary tract proc with CC except only cholecyst with or w/o C.D.E	3.0376	3.0940	1.9
194	7	SURG	Biliary tract proc w/o CC except only cholecyst with or w/o C.D.E	1.6333	1.5991	-2.1
195	7	SURG	Cholecystectomy with C.D.E. with CC	2.2744	2.4066	5.8
196	7	SURG	Cholecystectomy with C.D.E. w/o CC	1.4039	1.5073	7.4
197	7	SURG	Cholecystectomy except by Laparoscope, w/o C.D.E., with CC	1.6916	2.0082	18.7
198	7	SURG	Cholecystectomy except by Laparoscope, w/o C.D.E., w/o CC	0.8757	1.0432	19.1
199	7	SURG	Hepatobiliary diagnostic procedure for malignancy	2.3376	2.3557	0.8

200	7	SURG	Hepatobiliary diagnostic procedure for non-malignancy	2.7205	2.8054	3.1
201	7	SURG	Other hepatobiliary or pancreas O.R. procedures	2.5221	3.1526	25.0
202	7	MED	Cirrhosis and alcoholic hepatitis	1.2996	1.3176	1.4
203	7	MED	Malignancy of hepatobiliary system or pancreas	1.2158	1.2180	0.2
204	7	MED	Disorders of pancreas except malignancy	1.1158	1.1302	1.3
205	7	MED	Disorders of liver except malign, cirr, ALC hepa with CC	1.2249	1.2470	1.8
206	7	MED	Disorders of liver except malign, cirr, ALC hepa w/o CC	0.6113	0.6181	1.1
207	7	MED	Disorders of the biliary tract with CC	0.9814	0.9896	0.8
208	7	MED	Disorders of the biliary tract w/o CC	0.5564	0.5521	-0.8
209	8	SURG	Major joint and limb reattachment procedures—lower extremity	2.3686	2.3491	-0.8
210	8	SURG	Hip and femur procedures except major joint age >17 with CC	1.9077	1.8702	-2.0
211	8	SURG	Hip and femur procedures except major joint age >17 w/o CC	1.3307	1.3031	-2.1
212	8	SURG	Hip and femur procedures except major joint age 0-17	1.0345	1.4486	40.0
213	8	SURG	Amputation for musculoskeletal system and conn tissue disorders	1.7686	1.7485	-1.1
214	8	SURG	Back and neck procedures with CC	1.8686	1.8857	0.9
215	8	SURG	Back and neck procedures w/o CC	1.0905	1.0926	0.2
216	8	SURG	Biopsies of musculoskeletal system and connective tissue	2.0429	2.0570	0.7
217	8	SURG	Wnd debrid and skin graft except hand, for musculoskelet and conn tiss dis.	3.0601	3.0563	-0.1
218	8	SURG	Lower extrem and humer proc except hip, foot, femur age >17 with	1.4186	1.4195	0.1
219	8	SURG	Lower extrem and humer proc except hip, foot, femur age >17 w/o C ..	0.8956	0.9015	0.7
220	8	SURG	Lower extrem and humer proc except hip, foot, femur age 0-17	0.9392	0.9556	1.9
221	8	SURG	Knee procedures with CC	1.7828	1.7992	0.9
222	8	SURG	Knee procedures w/o CC	0.9544	0.9846	3.2
223	8	SURG	Major shoulder/elbow proc, or other upper extremity proc w CC	0.8087	0.8126	0.5
224	8	SURG	Shoulder, elbow or forearm proc, exc major joint proc w/o CC	0.6538	0.6698	2.4
225	8	SURG	Foot procedures	0.8212	0.8568	4.3
226	8	SURG	Soft tissue procedures with CC	1.3241	1.3096	-1.1
227	8	SURG	Soft tissue procedures w/o CC	0.6767	0.6866	1.5
228	8	SURG	Major thumb or joint proc, or oth hand or wrist proc w CC	0.7961	0.8225	3.3
229	8	SURG	Hand or wrist proc, except major joint proc, w/o CC	0.5539	0.5679	2.5

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
230	8	SURG	Local excision and removal of int fix devices of hip and femur	0.9179	0.9353	1.9
231	8	SURG	Local excision and removal of int fix devices except hip and femur	1.1044	1.1159	1.0
232	8	SURG	Arthroscopy	1.1792	1.1082	-6.0
233	8	SURG	Other musculoskelet sys and conn tiss O.R. proc with CC	1.8579	1.8454	-0.7
234	8	SURG	Other musculoskelet sys and conn tiss O.R. proc w/o CC	0.8957	0.9321	4.1
235	8	MED	Fractures of femur	1.0209	0.9730	-4.7
236	8	MED	Fractures of hip and pelvis	0.8128	0.7922	-2.5
237	8	MED	Sprains, strains, and dislocations of hip, pelvis and thigh	0.5496	0.5536	0.7
238	8	MED	Osteomyelitis	1.5435	1.5082	-2.3
239	8	MED	Pathological fractures and musculoskeletal and conn tiss malignancy ..	1.0415	1.0388	-0.3
240	8	MED	Connective tissue disorders with CC	1.1468	1.1488	0.2
241	8	MED	Connective tissue disorders w/o CC	0.5782	0.5682	-1.7
242	8	MED	Septic arthritis	1.1864	1.1356	-4.3
243	8	MED	Medical back problems	0.6834	0.7011	2.6
244	8	MED	Bone diseases and specific arthropathies with CC	0.7353	0.7437	1.1
245	8	MED	Bone diseases and specific arthropathies w/o CC	0.5043	0.4798	-4.9
246	8	MED	Non-specific arthropathies	0.5706	0.5962	4.5
247	8	MED	Signs and symptoms of musculoskeletal system and conn tissue	0.5682	0.5547	-2.4
248	8	MED	Tendonitis, myositis and bursitis	0.6750	0.6939	2.8
249	8	MED	Aftercare, musculoskeletal system and connective tissue	0.6965	0.6638	-4.7
250	8	MED	FX, sprn and disl of forearm, hand, foot age >17 with CC	0.7047	0.7174	1.8
251	8	MED	FX, sprn, strn and disl of forearm, hand, foot age >17 w/o CC	0.4395	0.4449	1.2
252	8	MED	FX, sprn, strn and disl of forearm, hand, foot age 0-17	0.3549	0.3615	1.9
253	8	MED	FX, sprn, strn and disl of uparm, lowleg ex foot age >17 with CC	0.7774	0.7706	-0.9
254	8	MED	FX, sprn, and disl of uparm, lowleg ex foot age >17 w/o CC	0.4231	0.4272	1.0
255	8	MED	FX, sprn, strn and disl of uparm, lowleg ex foot age 0-17	0.4709	0.4796	1.8
256	8	MED	Other musculoskeletal system and connective tissue diagnoses	0.8505	0.6366	-25.1

257	9	SURG	Total mastectomy for malignancy with CC	0.8950	0.8845	-1.2
258	9	SURG	Total mastectomy for malignancy w/o CC	0.7002	0.6959	-0.6
259	9	SURG	Subtotal mastectomy for malignancy with CC	0.8774	0.8372	-4.6
260	9	SURG	Subtotal mastectomy for malignancy w/o CC	0.5659	0.5743	1.5
261	9	SURG	Breast proc for non-malignancy except biopsy and local excision	0.7183	0.7272	1.2
262	9	SURG	Breast biopsy and local excision for non-malignancy	0.5345	0.6071	13.6
263	9	SURG	Skin graft and/or debrid for skin ulcer or cellulitis with CC	2.5403	2.4460	-3.7
264	9	SURG	Skin graft and/or debrid for skin ulcer or cellulitis w/o CC	1.2662	1.2346	-2.5
265	9	SURG	Skin graft and/or debrid except for skin ulcer or cellulitis w CC	1.3939	1.4065	0.9
266	9	SURG	Skin graft and/or debrid except for skin ulcer or cellulitis w/o	0.6978	0.7108	1.9
267	9	SURG	Perianal and pilonidal procedures	0.6245	0.6592	5.6
268	9	SURG	Skin, subcutaneous tissue and breast plastic procedures	0.7519	0.8198	9.0
269	9	SURG	Other skin, subcut tiss and breast proc with CC	1.6958	1.7166	1.2
270	9	SURG	Other skin, subcut tiss and breast proc w/o CC	0.6343	0.6456	1.8
271	9	MED	Skin ulcers	1.1970	1.1783	-1.6
272	9	MED	Major skin disorders with CC	1.0477	1.0206	-2.6
273	9	MED	Major skin disorders w/o CC	0.6583	0.6514	-1.0
274	9	MED	Malignant breast disorders with CC	1.1572	1.1183	-3.4
275	9	MED	Malignant breast disorders w/o CC	0.5957	0.5050	-15.2
275	9	MED	Non-malignant breast disorders	0.6085	0.6351	4.4
277	9	MED	Cellulitis age >17 with CC	0.9036	0.8917	-1.3
278	9	MED	Cellulitis age >17 w/o CC	0.5941	0.5828	-1.9
279	9	MED	Cellulitis age 0-17	0.7479	0.7618	1.9
280	9	MED	Trauma to the skin, subcut tiss and breast age >17 with CC	0.6808	0.6755	-0.8
281	9	MED	Trauma to the skin subcut tiss and breast age >17 w/o CC	0.4270	0.4195	-1.8
282	9	MED	Trauma to the skin subcut tiss and breast age 0-17	0.3476	0.3540	1.8
283	9	MED	Minor skin disorders with CC	0.7558	.07253	-4.0
284	9	MED	Minor skin disorders w/o CC	0.4450	0.4469	0.4
285	10	SURG	Amputat of lower limb for endoc, nutrit, and metab disorders	2.7519	2.5637	-6.8
286	10	SURG	Adrenal and pituitary procedures	2.3944	2.2821	-4.7
287	10	SURG	Skin grafts and wounds debrid for endoc, nutgrit, and metab disorder	2.1744	2.1927	0.8

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
288	10	SURG	O.R. procedures for obesity	2 0378	2 0725	1.7
289	10	SURG	Parathyroid procedures	1 0252	0 9920	-3.2
290	10	SURG	Thyroid procedures	0 7448	0 7637	2.5
291	10	SURG	Thyroglossal procedures	0 4896	0 5074	3.6
292	10	SURG	Other endocrine, nutri and metab O.R. proc with CC	2 8428	2 7658	-2.7
293	10	SURG	Other endocrine, nutri and metab O.R. proc w/o CC	1 1284	1 1010	-2.4
294	10	MED	Diabetes age >35	0 7491	0 7466	-0.3
295	10	MED	Diabetes age 0-35	0 7721	0 7562	-2.1
296	10	MED	Nutritional and misc metabolic disorders age >17 with CC	0 9410	0 9313	-1.0
297	10	MED	Nutritional and misc metabolic disorders age >17 w/o CC	0 5271	0 5244	-0.5
298	10	MED	Nutritional and misc metabolic disorders age 0-17	0 4777	0 5627	17.8
299	10	MED	Inborn errors of metabolism	0 8392	0 8271	-1.4
300	10	MED	Endocrine disorders with CC	1 1251	1 0982	-2.4
301	10	MED	Endocrine disorders w/o CC	0 5811	0 5777	-0.6
302	11	SURG	Kidney transplant	3 8885	3 8871	0.0
303	11	SURG	Kidney, ureter and major bladder procedures for neoplasm	2 6532	2 5929	-2.3
304	11	SURG	Kidney, ureter and major bladder proc for non-neopl with CC	2 4103	2 3897	-0.9
305	11	SURG	Kidney, ureter and major bladder proc for non-neopl w/o CC	1 1548	1 1127	-3.6
306	11	SURG	Prostatectomy with CC	1 2744	1 2474	-2.1
307	11	SURG	Prostatectomy w/o CC	0 6889	0 6620	-3.9
308	11	SURG	Minor bladder procedures with CC	1 4315	1 4452	1.0
309	11	SURG	Minor bladder procedures w/o CC	0 7287	0 7580	4.0
310	11	SURG	Transurethral procedures with CC	0 8880	0 9006	1.4
311	11	SURG	Transurethral procedures w/o CC	0 5153	0 5206	1.0
312	11	SURG	Urethral procedures age >17 with CC	0 8082	0 8334	3.1
313	11	SURG	Urethral procedures, age >17 w/o CC	0 4623	0 4551	-1.6
314	11	SURG	Urethral procedures, age 0-17	0 4389	0 4470	1.8

315	11	SURG	Other kidney and urinary tract O.R. procedures	2.0362	2.0341	-0.1
316	11	MED	Renal failure	1.2896	1.2903	0.1
317	11	MED	Admit for renal dialysis	0.5075	0.5194	2.3
318	11	MED	Kidney and urinary tract neoplasms with CC	1.1244	1.1215	-0.3
319	11	MED	Kidney and urinary tract neoplasms w/o CC	0.5069	0.5298	4.5
320	11	MED	Kidney and urinary tract infections age >17 with CC	0.9807	0.9677	-1.3
321	11	MED	Kidney and urinary tract infections age >17 w/o CC	0.6252	0.6112	-2.2
322	11	MED	Kidney and urinary tract infections age 0-17	0.6389	0.4952	-22.5
323	11	MED	Urinary stones with CC and/or ESW lithotripsy	0.7381	0.7290	-1.2
324	11	MED	Urinary stones w/o CC	0.3858	0.3864	0.2
325	11	MED	Kidney and urinary tract signs and symptoms age >17 with CC	0.6551	0.6607	0.9
326	11	MED	Kidney and urinary tract signs and symptoms age >17 w/o CC	0.4152	0.4024	-3.1
327	11	MED	Kidney and urinary tract signs and symptoms age 0-17	0.7038	0.7169	1.9
328	11	MED	Urethral stricture age >17 with CC	0.6363	0.6597	3.7
329	11	MED	Urethral stricture age >17 w/o CC	0.4113	0.3881	-5.6
330	11	MED	Urethral stricture age 0-17	0.2830	0.2882	1.8
331	11	MED	Other kidney and urinary tract diagnoses age >17 with CC	0.9765	0.9829	0.7
332	11	MED	Other kidney and urinary tract diagnoses age >17 w/o CC	0.5347	0.5430	1.6
333	11	MED	Other kidney and urinary tract diagnoses age 0-17	0.9590	0.9641	0.5
334	12	SURG	Major male pelvic procedures with CC	1.7728	1.7535	-1.1
335	12	SURG	Major male pelvic procedures w/o CC	1.3597	1.3630	0.2
336	12	SURG	Transurethral prostatectomy with CC	0.8704	0.8540	-1.9
337	12	SURG	Transurethral prostatectomy w/o CC	0.6066	0.6050	-0.3
338	12	SURG	Testes procedures, for malignancy	0.9386	0.9395	0.1
339	12	SURG	Testes procedures, non-malignancy age >17	0.7572	0.8093	6.9
340	12	SURG	Testes procedures, non-malignancy age 0-17	0.4401	0.4483	1.9
341	12	SURG	Penis procedures	0.9681	0.9646	-0.4
342	12	SURG	Circumcision age >17	0.5766	0.5848	1.4
343	12	SURG	Circumcision age 0-17	0.3845	0.3916	1.8
344	12	SURG	Other male reproductive system O.R. procedures for malignancy	1.0568	1.0183	-3.6
345	12	SURG	Other male reproductive system O.R. proc except for malignancy	0.7521	0.7344	-2.4

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
346	12	MED	Malignancy, male reproductive system, with CC	0.9906	0.9338	-5.7
347	12	MED	Malignancy, male reproductive system, w/o CC	0.5120	0.4928	-3.8
348	12	MED	Benign prostatic hypertrophy with CC	0.6815	0.6856	0.6
349	12	MED	Benign prostatic hypertrophy w/o CC	0.3952	0.3904	-1.2
350	12	MED	Inflammation of the male reproductive system	0.6707	0.6668	-0.6
351	12	MED	Sterilization, male	0.3384	0.3447	1.9
352	12	MED	Other male reproductive system diagnoses	0.5801	0.5326	-8.2
353	13	SURG	Pelvic evisceration, radical hysterectomy and radical vulvectomy	1.9031	1.9624	3.1
354	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malign w/o CC	1.3686	1.3794	0.8
355	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malign w/o CC	0.8493	0.8717	2.6
356	13	SURG	Female reproduction system reconstructive procedures	0.7030	0.7096	0.9
357	13	SURG	Uterine and adnexa proc for ovarian or adnexal malign	2.3097	2.3153	0.2
358	13	SURG	Uterine and adnexa proc for non-malignancy with CC	1.1066	1.1042	-0.2
359	13	SURG	Uterine and adnexa proc for non-malignancy w/o CC	0.7723	0.7834	1.4
360	13	SURG	Vagina, cervix and vulva procedures	0.8024	0.8126	1.3
361	13	SURG	Laparoscopy and incisional tubal interruption	0.9767	1.0037	2.8
362	13	SURG	Endoscopic tubal interruption	0.5057	0.5151	1.9
363	13	SURG	D&C, conization and radio-implant, for malignancy	0.6251	0.6340	1.4
364	13	SURG	D&C, conization except for malignancy	0.5659	0.5930	4.8
365	13	SURG	Other female reproductive system O.R. procedures	1.7093	1.7034	-0.3
366	13	MED	Malignancy, female reproductive system with CC	1.2158	1.1948	-1.7
367	13	MED	Malignancy, female reproductive system w/o CC	0.4808	0.4769	-0.8
368	13	MED	Infections, female reproductive system	0.8820	0.9489	7.6
369	13	MED	Menstrual and other female reproductive system disorders	0.5321	0.5201	-2.3
370	14	SURG	Cesarean section with CC	0.8916	0.8699	-2.4
371	14	SURG	Cesarean section w/o CC	0.6461	0.6289	-2.7
372	14	MED	Vaginal delivery with complicating diagnoses	0.4619	0.5174	12.0

373	14	MED	Vaginal delivery w/o complicating diagnosis	0.3182	0.3247	2.0
374	14	SURG	Vaginal delivery with sterilization and/or D&C	0.6297	0.5859	-7.0
375	14	SURG	Vaginal delivery with O.R. proc except steril and/or D&C	0.6921	0.7049	1.8
376	14	MED	Postpartum and post abortion diagnoses w/o O.R. procedure	0.3247	0.3894	19.9
377	14	SURG	Postpartum and post abortion diagnoses with O.R. procedure	0.8392	0.8600	2.5
378	14	MED	Ectopic pregnancy	0.7694	0.7580	-1.5
379	14	MED	Threatened abortion	0.2743	0.3346	22.0
380	14	MED	Abortion w/o D&C	0.3430	0.2958	-13.8
381	14	SURG	Abortion with D&C, aspiration curettage or hysterotomy	0.4326	0.3943	-8.9
382	14	MED	False labor	0.1486	0.1240	-16.6
383	14	MED	Other antepartum diagnoses with medical complications	0.3947	0.4059	2.8
384	14	MED	Other antepartum diagnoses w/o medical complications	0.2701	0.2620	-3.0
385	15	MED	Neonates, died or transferred to another acute care facility	1.2418	1.2648	1.9
386	15	MED	Extreme immaturity or respiratory distress syndrome, neonate	3.7035	3.7722	1.9
387	15	MED	Prematurity w major problems	1.8545	1.8889	1.9
388	15	MED	Prematurity w/o major problems	1.1747	1.1965	1.9
389	15	MED	Full term neonate w major problems	1.4229	1.5295	7.5
390	15	MED	Neonate w other significant problems	1.1340	0.9165	-19.2
391	15	MED	Normal newborn	0.2252	0.2294	1.9
392	16	SURG	Splenectomy age >17	3.1287	3.3043	5.6
393	16	SURG	Splenectomy age 0-17	1.5437	1.5723	1.9
394	16	SURG	Other O.R. procedures of the blood and blood forming organs	1.5966	1.6781	5.1
395	16	MED	Red blood cell disorders age >17	0.7881	0.8057	2.2
396	16	MED	Red blood cell disorders age 0-17	0.6802	0.3079	54.7
397	16	MED	Coagulation disorders	1.1905	1.2292	3.3
398	16	MED	Reticuloendothelial and immunity disorders with CC	1.2091	1.2431	2.8
399	16	MED	Reticuloendothelial and immunity disorders w/o CC	0.6735	0.6822	1.3
400	17	SURG	Lymphoma and leukemia w major O.R. procedure	2.5572	2.5309	-1.0
401	17	SURG	Lymphoma and non-acute leukemia w other O.R. proc w CC	2.3497	2.3778	1.2
402	17	SURG	Lymphoma and non-acute leukemia w other O.R. proc w/o CC	0.8536	0.8850	3.7
403	17	MED	Lymphoma and non-acute leukemia w CC	1.6827	1.6757	-0.4

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
404	17	MED	Lymphoma and non-acute leukemia w/o CC	0.7428	0.7377	-0.7
405	17	MED	Acute leukemia w/o major O.R. procedures age 0-17	1.0565	1.0761	1.9
406	17	SURG	Myeloprolif disorder or poorly diff neopl w maj O.R. proc with CC	2.7669	2.6133	-5.6
407	17	SURG	Myeloprolif disorder or poorly diff neopl w maj O.R. proc w/o CC	1.1999	1.1204	-6.6
408	17	SURG	Myeloprolif disorder or poorly diff neopl w other O.R. proc	1.3279	1.4241	7.2
409	17	MED	Radiotherapy	0.9886	0.9922	0.4
410	17	MED	Chemotherapy without acute leukemia as secondary diagnosis	0.6095	0.6679	9.6
411	17	MED	History of malignancy w/o endoscopy	0.4256	0.4152	-2.4
412	17	MED	History of malignancy w endoscopy	0.4257	0.4758	11.8
413	17	MED	Other myeloprolif dis or poorly diff neopl diag with CC	1.3335	1.3849	3.9
414	17	MED	Other myeloprolif dis or poorly diff neopl diag w/o CC	0.6857	0.7091	3.4
415	18	SURG	O.R. procedure for infectious and parasitic diseases	3.5162	3.5723	1.6
416	18	MED	Septicemia age >17	1.5222	1.5141	-0.5
417	18	MED	Septecemia age 0-17	0.8974	0.7002	-22.0
418	18	MED	Postoperative and post-traumatic infections	0.9679	0.9665	-0.1
419	18	MED	Fever of unknown origin age > 17 with CC	0.9500	0.9511	0.1
420	18	MED	Fever of unknown origin age >17 w/o cc	0.6510	0.6365	-2.2
421	18	MED	Viral illness age >17	0.6882	0.6758	-1.8
422	18	MED	Viral illness and fever of unknown origin age 0-17	0.7629	0.5888	-22.8
423	18	MED	Other infectious and parasitic diseases diagnoses	1.5976	1.6246	1.7
424	19	SURG	O.R. procedure with principal diagnoses of mental illness	2.4058	2.4684	2.6
425	19	MED	Acute adjust react and disturbances of psychosocial dysfunction	0.7045	0.7127	1.2
426	19	MED	Depressive neuroses	0.6023	0.6128	1.7
427	19	MED	Neuroses except depressive	0.6322	0.6184	-2.2
428	19	MED	Disorders of personality and impulse control	0.7703	0.7084	-8.0
428	19	MED	Organic disturbances and mental retardation	0.9460	0.9379	-0.9
430	19	MED	Psychoses	0.9040	0.9153	1.2

431	19	MED	Childhood mental disorders	0.5980	0.6980	16.7
432	19	MED	Other mental disorder diagnoses	0.7113	0.7357	3.4
433	20	MED	Alcohol/drug abuse or dependence, left AMA	0.3545	0.3512	-0.9
434	20	MED	Alc/drug abuse or dependence, detox or other sympt trt with CC	0.7494	0.7321	-2.3
435	20	MED	Alc/drug abuse or dependence, detox or other sympt trt w/o CC	0.4818	0.4529	-6.0
436	20	MED	Alc/drug dependence with rehabilitation therapy	0.9869	0.9691	-1.8
437	20	MED	Alc/drug dependence, combined rehab and detox therapy	1.0888	0.9970	-8.4
438	....		No longer valid	NV	NV	NV
439	21	SURG	Skin grafts for injuries	1.2126	1.3853	14.2
440	21	SURG	Wound debridements for injuries	1.8359	1.7125	-6.7
441	21	SURG	Hand procedures for injuries	0.7321	0.7122	-2.7
442	21	SURG	Other O.R. procedures for injuries with CC	1.9106	1.9292	1.0
443	21	SURG	Other O.R. procedures for injuries w/o CC	0.7518	0.7398	-1.6
444	21	MED	Traumatic injury age >17 with CC	0.7643	0.7431	-2.8
445	21	MED	Traumatic injury age >17 w/o CC	0.4649	0.4635	-0.3
446	21	MED	Traumatic injury age 0-17	0.4869	0.4959	1.8
447	21	MED	Allergic reactions age >17	0.4919	0.4869	-1.0
448	21	MED	Allergic reactions age 0-17	0.3523	0.3588	1.8
449	21	MED	Poisoning and toxic effects of drugs age >17 with cc	0.7889	0.7929	0.5
450	21	MED	Poisoning and toxic effects of drugs age >17 w/o cc	0.4325	0.4224	-2.3
451	21	MED	Poisoning and toxic effects of drugs age 0-17	0.5268	1.0266	94.9
452	21	MED	Complications of treatment with CC	0.8550	0.82232	-3.7
453	21	MED	Complications of treatment w/o CC	0.4175	0.4177	0.0
454	21	MED	Other injury, poisoning and toxic eff diag with CC	0.8873	0.9107	2.6
455	21	MED	Other injury, poisoning and toxic eff diag w/o CC	0.4130	0.4166	0.9
456	22	MED	Burns, transferred to another acute care facility	1.7285	2.1688	25.5
457	22	MED	Extensive burns w/o O.R. procedure	2.0147	1.6312	-19.0
458	22	SURG	Non-extensive burns with graft	3.8787	3.7459	-3.4
459	22	SURG	Non-extensive burns with wound debridement or other O.R. proc	1.8906	2.1042	11.3
460	22	MED	Non-extensive burns w/o O.R. procedure	1.0032	1.0508	4.7

TABLE D-21.—DRG RELATIVE WEIGHTS FROM FISCAL YEAR 1993 TO FISCAL YEAR 1994—Continued

DRG	MDC	Type	Title	Fiscal year		Percent change
				1993 weight	1994 weight	
461	23	SURG	O.R. proc with diagnoses of other contact with health services	0.8808	0.8656	-1.7
462	23	MED	Rehabilitation	1.7805	1.7205	-3.4
463	23	MED	Signs and symptoms with CC	0.7277	0.7249	-0.4
464	23	MED	Signs and symptoms w/o CC	0.4567	0.4591	0.5
465	23	MED	Aftercare with history of malignancy as secondary diagnosis	0.3531	0.3740	5.9
466	23	MED	Aftercare w/o history of malignancy as secondary diagnosis	0.5328	0.5516	3.5
467	23	MED	Other factors influencing health status	0.4469	0.4168	-6.7
468	(1)	SURG	Extensive O.R. procedure unrelated to principal diagnosis	3.4195	3.4842	1.9
469	(1)		Principal diagnosis invalid as discharge diagnosis	NV	NV	NV
470	(1)		Ungroupable	NV	NV	NV
471	(1)		Bilateral or multiple major joint procs of lower extremity	3.8976	3.8651	-0.8
472	22	SURG	Extensive burns with O.R. procedure	11.7093	11.633	-0.1
473	17	MED	Acute leukemia w/o major O.R. procedure age >17	3.4402	3.5702	3.8
474	(1)		No longer valid	NV	NV	NV
475	4	MED	Respiratory system diagnosis with ventilator support	3.5965	3.7175	3.4
476	(1)	SURG	Prostatic O.R. procedure unrelated to principal diagnosis	2.2014	2.2361	1.6
477	(1)	SURG	Non-extensive O.R. procedure unrelated to principal diagnosis	1.4337	1.4628	2.0
478	5	SURG	Other vascular procedures with CC	2.1645	2.1897	1.2
479	5	SURG	Other vascular procedures w/o CC	1.2718	1.3027	2.4
480	.....		Liver transplant	20.1614	19.4679	-3.4
481	(1)	SURG	Bone marrow transplant	15.2244	14.3709	-5.6
482	(1)	SURG	Tracheostomy for face, mouth and neck diagnoses	3.4826	3.5756	2.7
483	(1)	SURG	Tracheostomy except for face, mouth and neck diagnoses	16.6590	16.9858	2.0
484	24	SURG	Craniotomy for multiple significant trauma	6.5706	5.6612	-13.8
485	24	SURG	Limb reattach, hip and femur procs for multi sign trauma	3.1669	3.2361	2.2
486	24	SURG	Other O.R. procedures for multiple significant trauma	4.8231	4.6756	-3.1
487	24	MED	Other multiple significant trauma	1.9406	1.9379	-0.1
488	25	SURG	HIV with extensive O.R. procedure	4.1539	4.3859	5.6

489	25	MED	HIV with major related condition	1.9151	1.8468	-3.6
490	25	MED	HIV with or w/o other related condition	1.1285	1.1174	-1.0
491	8	SURG	Major joint and limb reattachment procedures-upper extremity	1.5676	1.6092	2.7
492	17	MED	Chemotherapy with acute leukemia as secondary diagnosis	2.7815	3.5861	28.9
493	7	SURG	Laparoscopic cholecystectomy with/out C.D.E. with CC	NC	1.5268	NC
494	7	SURG	Laparoscopic cholecystectomy with/out C.D.E. with/out CC	NC	0.8233	NC

¹ DRG definition substantially revised for discharges occurring on or after October 1, 1991.

NC Denotes a new DRG category defined for discharges occurring on or after October 1, 1991.

NV Denotes a DRG category that is not valid for classification and payment under PPS.

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APPENDIX E. MEDICARE REIMBURSEMENT TO PHYSICIANS

PHYSICIAN PAYMENT REFORM

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) provided for the implementation, beginning January 1, 1992, of a new payment system for physicians' services paid for by Medicare. A new fee schedule payment system replaces the previous reasonable charge payment system. The new system was enacted in response to two principal concerns. The first was the rapid escalation in program payments. Over the 1965–89 period, Medicare spending for physicians' services had increased at an average annual rate of 11.7 percent, outstripping both the increase in medical care inflation and the rate of growth in the number of Medicare enrollees. The second concern was that the use of the reasonable charge payment had led, in many cases, to payments which were not directly related to the resources used.

Under the new system, payments are made under a fee schedule which is based on a resource-based relative value scale (RBRVS). The new system is being phased in over the 1992–96 period. OBRA 1989 also created a volume performance standard to moderate the rate of growth in physician expenditures. Further, it increased protections for beneficiaries by placing more stringent limits on amounts that physicians can bill in excess of Medicare's approved payment amount. Taken together, these three elements are referred to as the three-part physician payment reform package. The legislation also authorized increased funding for research on patient outcomes for selected medical treatments and surgical procedures to assess their appropriateness, necessity, and effectiveness. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) contained several modifications and clarifications to the OBRA 1989 provisions. Further changes were included in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

The Department of Health and Human Services (DHHS) issued final implementing regulations on November 25, 1991. Additional regulations were issued on November 25, 1992 and December 2, 1993.

MEDICARE FEE SCHEDULE

The Secretary of DHHS is required to establish a fee schedule before January 1 of each year that sets payment amounts for all physicians' services furnished in all fee schedule areas for the year. The fee schedule amount for a service is equal to the product of:

The *relative value for the service*;

The *geographic adjustment factor* (GAF) for the service for the fee schedule area; and

The *national dollar conversion factor* for the year.

Relative value unit. The relative value unit (RVU) for each service has three components.

The *physician work component* reflects physician time and intensity, including activities before and after patient contact.

The *practice expense or overhead component* includes all categories of practice expenses (exclusive of malpractice liability insurance costs). Included are office rents, employee wages, physician compensation, and physician fringe benefits.

The *malpractice expense component* reflects costs of obtaining malpractice insurance.

The proportion that each component represents of the total RVU varies by service.

Geographic adjustment factor. The second major factor used in calculation of the fee schedule is the geographic adjustment factor (GAF) for the fee schedule area. There are currently 217 fee schedule areas nationwide.

The GAF is designed to account for geographic variations in the costs of practicing medicine and obtaining malpractice insurance as well as a portion of the difference in physicians' incomes that is not attributable to these factors.

The GAF is the sum of three indices. Separate geographic practice cost indices (GPCIs) have been developed for each of the three components of the RVU, namely a work GPCI, a practice expense or overhead GPCI, and a malpractice GPCI. In effect, a separate geographic adjustment is made for each component. However, as required by law, only one-quarter of the geographic variation in physician work resource costs is taken into account in the formula. (Table E-25 at the end of this chapter shows the GAF values for each of the 217 fee schedule areas nationwide.)

The three GPCI-adjusted RVU values are summed to produce an indexed RVU for each locality.

Conversion factor. The conversion factor is a dollar multiplier which converts the geographically adjusted relative value for a service to an actual payment amount for the service. The law requires the establishment of an initial dollar conversion factor. The conversion factor is updated annually beginning in 1992.

The law required the calculation of an initial dollar conversion factor which was *budget neutral* relative to 1991 predicted expenditure levels. This means that if the initial conversion factor had applied in 1991, Medicare spending would equal what was projected to be spent under the reasonable charge payment system in that year. The law also contained provisions relating to payment calculations during the 1992-96 phase-in period; these are the transition provisions. The Department's final implementing regulations included an adjustment to reconcile the calculations required under both the budget neutrality and transition provisions. (This adjustment to the "adjusted historical payment basis" is discussed under "Transition rules" below.)

The initial dollar conversion factor was set at \$30.42. The 1992 update was set at 1.9 percent. (See discussion of update calculation below.) Therefore the 1992 conversion factor was \$31.001.

In 1993 two conversion factors applied—one for surgical services and one for nonsurgical services. The 1993 conversion factor for

surgical services was \$31.96, and the conversion factor for nonsurgical services was \$31.25.

Beginning in 1994, a third conversion factor applies for primary care services. The 1994 conversion factor for surgical services is \$35.15; the conversion factor for primary care services is \$33.72; the conversion factor for other nonsurgical services is \$32.91.

Payment formula. In simplified terms the payment for each service is calculated as follows:

$$\text{PAYMENT} = \text{CF} \times \left[(\text{RVU}_{\text{work}} \times \text{GPCI}_{\text{work}}) + (\text{RVU}_{\text{practice expense}} \times \text{GPCI}_{\text{practice expense}}) + (\text{RVU}_{\text{malpractice}} \times \text{GPCI}_{\text{malpractice}}) \right]$$

Where:

CF=conversion factor

RVU_{work}=physician work relative value units for the service;

GPCI_{work}=geographic practice cost index value for physician work in the locality (the value reflects only one-quarter of the variation in physician work as required by law);

RVU_{practice expense}=practice expense or overhead relative value units for the service;

GPCI_{practice expense}=geographic practice cost index value for practice expense or overhead applicable in the locality;

RVU_{malpractice}=malpractice relative value units for the service;

GPCI_{malpractice}=geographic practice cost index value for malpractice applicable in the locality.

Transition rules. The law establishes specific payment rules for the 1992–1996 phase-in period. To determine payments in 1992, comparisons were made between the fee schedule amount and the “adjusted historical payment basis” (AHPB) in the payment locality. Generally, the AHPB was equal to the average Medicare allowance for the service in the locality in 1991, updated to 1992. Implementing regulations applied a 5.5 percent downward adjustment to this amount in order to maintain budget neutrality over the 5-year transition period.

If the reduced AHPB in a locality was less than 15 percent over or under the fee schedule amount, payments were made on the basis of the fee schedule beginning in 1992. A transition was provided in the case of differences larger than 15 percent. In 1992, the reduced AHPB amounts were increased or decreased by *15 percent of the fee schedule amount*, whichever was appropriate. Thus, for a service more than 15 percent *below* the fee schedule the payment equaled the reduced AHPB *plus* 15 percent fee schedule amount. For a service more than 15 percent *above* the fee schedule, the payment equaled the reduced AHPB *minus* 15 percent fee schedule amount.

For 1993–95, payment is based on a blend of the previous year’s amount (updated to the current year) and the fee schedule amount; over the period, a gradually increasing portion is based on the fee schedule. In 1993, 75 percent was based on the previous year’s amount adjusted by the update factor specified for the year and 25 percent was based on the fee schedule amount for the year. The percentage attributable to the previous year’s fee is reduced to 67 percent in 1994 and 50 percent in 1995. All services are paid on the basis of the fee schedule beginning in 1996.

MEDICARE VOLUME PERFORMANCE STANDARDS; CONVERSION FACTOR
UPDATE

A key element of the fee schedule is the conversion factor. One consideration in establishing the annual update in the conversion factor is whether efforts to stem the annual rate of growth in physician payments have succeeded. This is measured by the Medicare volume performance standard (MVPS).

Medicare volume performance standards. The law requires the calculation of annual MVPSs, which are standards for the rate of expenditure growth. The purpose of these standards is to provide an incentive for physicians to get involved in efforts to stem expenditure increases. The relationship of actual expenditures to the MVPS is one factor used in determining the annual update in the conversion factor.

Implementation of the MVPS provision began in fiscal year 1990. OBRA 1989 effectively set a performance standard rate of increase for fiscal year 1990 for all physicians' services and specified a process for determining the standard in future years. OBRA 1990 specified that the fiscal year 1991 MVPS rates of increase were to be set at the estimated baseline percentage increase in expenditures, minus 2 percentage points. The amount of this reduction is referred to as the "performance standard factor." OBRA 1993 increased the performance standard factor from 2.0 to 3.5 percentage points for 1994, and to 4 percent points for each succeeding year. OBRA 1990 also provided, beginning for fiscal year 1991, for the calculation of a standard for all physicians' services, and for two subcategories of physicians' services: surgical services and other services. Beginning in fiscal year 1994, OBRA 1993 required separate MVPS rates of increase for surgical, primary care, and other nonsurgical services.

Generally, the Congress is expected to specify the performance standard rates of increase. The Secretary of DHHS is required to make a recommendation to the Congress by April 15 each year. In making the recommendation, the Secretary is to consider inflation, changes in the number of part B enrollees, changes in technology, appropriateness of care, and access to care. The Physician Payment Review Commission (PhysPRC), a Congressional advisory body, is required to review the Secretary's recommendation and submit its own recommendation by May 15.

The Congress is then expected to establish the standard rates of increase. If the Congress does not specify the MVPS, however, the rates of increase are determined based on a default formula. The default standard is the product of the following four factors reduced by a performance standard factor:

Secretary's estimate of the weighted average percentage increase in physicians' fees for services for the portions of the calendar years included in the fiscal year involved;

Secretary's estimate of the percentage change from the previous year in the number of part B enrollees;

Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services for the preceding 5 fiscal years; and

Secretary's estimate of the percentage change in physician expenditures in the fiscal year (not taken into account above) which will result from changes in law or regulations.

In fiscal year 1991, the performance standard factor was 1 percentage point; this increased to 1.5 percentage points in fiscal year 1992, to 2 percentage points in fiscal year 1993, to 3.5 percentage points in fiscal year 1994, and to 4.0 percentage points in subsequent years.

The MVPS for fiscal year 1994 is based on the default formula. It is set at 8.6 percent for surgical services, 10.5 percent for primary care services, 9.2 percent for other nonsurgical services, and 9.3 percent for all physicians' services (see table E-1).

TABLE E-1.—MEDICARE VOLUME PERFORMANCE STANDARDS

[In percent]

Fiscal year	Surgical	Nonsurgical	Primary Care	All
1990	(1)	(1)	(2)	9.1
1991	3.3	8.6	(2)	7.3
1992	6.5	11.2	(2)	10.0
1993	8.4	10.8	(2)	10.0
1994	8.6	9.2	10.5	9.3

¹ Separate performance standards for surgical and nonsurgical services not required for fiscal year 1990.

² Separate performance standards for primary care services not required for fiscal years 1990-93.

TABLE E-2.—CBO PROJECTIONS OF MEDICARE VOLUME PERFORMANCE STANDARDS¹

[Fiscal years, in percent]

	1993	1994	1995	1996	1997	1998	1999
MVP standard overall ²	10.0	9.3	10.0	4.8	5.0	4.0	4.1
Growth in overall expenditures	5.5	8.9	11.2	10.7	11.1	9.6	9.1
Difference	4.5	0.4	-1.3	-6.0	-6.1	-5.6	-5.1
Maximum allowable reduction	-2.0	-2.5	-5.0	-5.0	-5.0	-5.0	-5.0
MEI adjustment	-1.3	9.3	4.5	0.4	-1.3	-5.0	-5.0
Legislative adjustments ³	0.0	-2.3	-2.2	0.0	0.0	0.0	0.0
Projected MEI (calendar year)	2.7	2.3	2.9	2.8	2.7	2.6	2.5
Adjusted overall MEI (calendar year)	1.4	9.3	5.2	3.2	1.4	-2.4	-2.5

¹ Because of uncertainty over the redistributive effects of the physician fee schedule on the categories of services, CBO projects only an overall default standard for 1995-99.

² The 1993 and 1994 Standards were announced by the Secretary of HHS. Standard values for 1995-99 are CBO projections.

³ The increase in physician's fees in 1994 and 1995 were reduced by OBRA 1993 legislation. Surgical services were reduced by 3.6% in 1994 and 2.7% in 1995. Medical services (other than primary care) were reduced by 2.6% in 1994, 2.7% in 1995. The numbers shown in this table reflect a weighted reduction across all physician services that were used by CBO to calculate an overall update.

Source: Congressional Budget Office.

Table E-2 shows CBO projections of the MVPS and components of the MVPS through fiscal year 1999.

Conversion factor update. Annual updates in payments under the fee schedule are made by updating the dollar conversion factor. The

Congress is generally expected to specify the percentage increase in the conversion factor. In April of each year (beginning in 1991), the Secretary of DHHS is required to recommend to the Congress an update (or updates) in the conversion factor for the following year.

In making the update recommendation, the Secretary is required to consider a number of factors including the percentage change in actual expenditures in the preceding fiscal year compared to the MVPS for that year, changes in volume and intensity of services, beneficiary access to care, and the increase in the Medicare Economic Index (MEI). The MEI is a percentage figure which is revised annually; it has been used in the program to limit annual increases in recognized fees. The MEI is generally intended to reflect annual increases in the costs of operating a medical practice; however, for several years the MEI percentage was set by the Congress. (See table E-3 for a history of MEI updates.)

The PhysPRC is required to review the Secretary's update recommendation and submit its own recommendation to Congress by May 15 of each year.

For 1993, separate updates were required for surgical and nonsurgical services. Beginning with the 1994 update, OBRA 1993 required separate updates for surgical services, primary care services, and other nonsurgical services. OBRA 1993 also modified the MVPS by including anesthesia services in the MVPS for surgical services.

The Congress either specifies the update to the conversion factor or a default formula, specified in law, applies. The *default fee update* is equal to the Secretary's estimate of the MEI increased or decreased by the percentage difference between the increase in actual expenditures and the MVPS for the second preceding fiscal year. (Thus, the 1994 updates reflect actual fiscal year 1992 experience.) However, the law specifies a lower limit on the default update. Before the enactment of OBRA 1993, the maximum downward adjustment in the update was 2 percentage points in 1992 and 1993, 2.5 percentage points in calendar years 1994 and 1995, and 3 percentage points for any succeeding calendar year. However, OBRA 1993 changed for maximum downward adjustment for 1995 and any succeeding year to 5.0 percentage points. There is no restriction on upward adjustments to the MEI.

OBRA 1993 required the MEI for calendar year 1994 to be reduced by 3.6 percentage points for surgical services and 2.6 percentage points for nonsurgical services other than primary care services. OBRA 1993 also required the MEI to be reduced by 2.7 percentage points in 1995 for both surgical and nonprimary care nonsurgical services. Primary care services were exempt from the statutory reductions in the MEI in 1994 and 1995.

The default formula was used to calculate the update for calendar year 1994. The 1994 MEI is 2.3 percent. The conversion factor was increased to 10 percent for surgical services, 7.9 percent for primary care services, and 5.3 percent for other nonsurgical services. The fee updates were set above the MEI because the growth rates in spending for both surgical and nonsurgical services were less than the fiscal year 1992 volume performance standards. (See table E-3 for previous fee schedule updates.)

TABLE E-3.—MEDICARE UPDATE FACTORS FROM 1973–1994

Medicare economic index	Index value	Annual increase (percent)
July 1, 1973	1.000	NA
July 1, 1975 to June 30, 1976	1.179	17.90
July 1, 1976 to June 30, 1977	1.276	8.23
July 1, 1977 to June 30, 1978	1.357	6.35
July 1, 1978 to June 30, 1979	1.426	5.08
July 1, 1979 to June 30, 1980	1.533	7.50
July 1, 1980 to June 30, 1981	1.658	8.15
July 1, 1981 to June 30, 1982	1.790	7.96
July 1, 1982 to June 30, 1983	1.949	8.88
July 1, 1983 to June 30, 1984	2.063	5.85
July 1, 1984 to Apr. 30, 1986	2.063	¹ 0
May 1, 1986 to Dec. 31, 1986	2.148	² 4.15
Jan. 1, 1987 to Mar. 31, 1988	2.217	³ 3.20

	Primary care services	Other services	Anesthesiology, radiology, & overvalued procedures ⁸
Apr. 1, 1988 to Dec. 31, 1988	⁴ 3.60	⁴ 1.00	1.00
Jan. 1, 1989 to Mar. 31, 1990	⁵ 3.00	⁵ 1.00	1.00
Apr. 1, 1990 to Dec. 31, 1990	⁶ 4.20	⁷ 2.00	0
Jan. 1, 1991 to Dec. 31, 1991	2.00	0	0

Physician fee schedule update	Primary care services	Surgical services	Other nonsurgical services
Jan. 1, 1992 to Dec. 31, 1992	1.90	1.90	1.90
Jan. 1, 1993 to Dec. 31, 1993	0.80	3.10	0.80
Jan. 1, 1994 to Dec. 31, 1994	7.90	10.00	5.30

¹ MEI was held constant during fee freeze.

² Percentage increase was mandated by Public Law 99-272 and applied only to participating physicians.

³ Percentage increase was mandated by Public Law 99-509 and applied to both participating and nonparticipating physicians. Prevailing charges of nonparticipating physicians were 96 percent of the prevailing charges for participating physicians.

⁴ Percentage increase was mandated by Public Law 100-203. Prevailing charges for services provided by nonparticipating physicians are 95.5 percent of the prevailing charges for participating physicians.

⁵ Percentage increase was mandated by Public Law 100-203. Prevailing charges for services provided by nonparticipating physicians are 95 percent of the prevailing charges for participating physicians.

⁶ Prevailing charges for services provided by nonparticipating physicians are 95 percent of the prevailing charges for participating physicians.

⁷ Percentage increase was mandated by P.L. 100-239. Prevailing charges for services provided by nonparticipating physicians are 95 percent of the prevailing charges for participating physicians.

⁸ Services considered overpriced are specified in table 2 in the "Joint Explanatory Statement of the Committee of Conference" submitted with the conference report to accompany P.L. 100-239.

NA—Not applicable.

Source: Health Care Financing Administration, Office of the Actuary, Office of Medicare and Medicaid Cost Estimates.

LIMITS ON BENEFICIARY LIABILITY

Medicare pays 80 percent of the fee schedule amount after the beneficiary has met the \$100 deductible for the year. The beneficiary is responsible for the remaining 20 percent, known as coinsurance. If a physician does not accept *assignment* on a claim, the beneficiary may be liable for additional charges known as *balance billing charges*. However, the law places certain limits on these balance billing charges.

Assignment/participation. The new payment system retains the Medicare concepts of assignment and participation. As under the previous reasonable charge payment system, a physician is able to choose whether or not to accept assignment on a claim paid under the fee schedule. In the case of an assigned claim, the physician bills the program directly and is paid an amount equal to 80 percent of the fee schedule amount (less any unmet deductible). The physician may not charge the beneficiary more than the applicable deductible and coinsurance amounts. In the case of nonassigned claims, the physician still bills the program directly; however, Medicare payment is made to the beneficiary. In addition to the deductible and coinsurance amounts, the beneficiary is liable for the difference between the fee schedule amount and the physician's actual charge, subject to certain limits. This is known as the *balance billed* amount.

A physician may become a *participating physician*. A participating physician is one who voluntarily enters into an agreement with the Secretary of DHHS to accept assignment on all claims for the forthcoming year. Medicare patients of these physicians never face balance billing charges.

The law includes a number of incentives for physicians to become participating physicians, chief of which is higher recognized fee schedule amounts. The fee schedule amount for a nonparticipating physician is only 95 percent of the recognized amount for a participating physician.

The law specifies that physicians are required to accept assignment on all claims for persons who are dually eligible for Medicare and Medicaid. This includes "qualified Medicare beneficiaries" (QMBs); these are persons with incomes below poverty for whom Medicaid is required to pay Medicare premiums and cost-sharing charges.

Balance billing limits. For several years, the law has placed limits on balance billing charges. From 1987-90, the program placed a physician-specific limit on actual charges of physicians which was known as the maximum allowable actual charge or (MAAC). Beginning in 1991, new limits were phased in.

The new limiting charges are set at a maximum percentage above the recognized payment amount (the prevailing charge in 1991 or the Medicare fee schedule amount in subsequent years) for nonparticipating physicians. Recognized payment amounts for nonparticipating physicians are 95 percent of such amounts for participating physicians. The limiting charges are therefore a percentage of this reduced amount.

In 1991, a physician's limiting charge was the same percentage (not to exceed 25 percent) above the 1991 recognized payment

amount as their 1990 MAAC was above the 1990 recognized payment amount. This was referred to as the 125-percent limit. In 1991 only, the limit for evaluation and management services was 140 percent.

In 1992, a physician's limiting charge was the same percentage (not to exceed 20 percent) above the 1992 payment amount as their 1991 limiting charge was above the 1991 recognized payment amount. This was referred to as the 120-percent limit. For 1993 and subsequent years, the limiting charge for nonparticipating physicians is 115 percent of the fee schedule amount.

Because certain items and services are excluded from the physician fee schedule, beneficiaries do not have limiting charge protection for them. OBRA 1993 expanded the scope of the limiting charge protection, however. Beginning in 1994, the limiting charge provision applies to drugs and biologicals that are furnished incident to physicians' services. In addition, the limiting charge provisions now apply to nonparticipating suppliers.

MEDICAL CARE OUTCOMES AND EFFECTIVENESS RESEARCH

In the fourth part of the physician payment reform package, Congress created a new agency, the Agency for Health Care Policy and Research, which replaced the then existing National Center for Health Services Research in the Public Health Service. The mission of the new agency is to enhance the quality, appropriateness and effectiveness of health care services and access to such services. These goals are to be accomplished by establishing a broad base of scientific research and promoting improvements in the clinical practice of medicine and the organization, financing and delivery of health care services.

Specifically, the agency is directed to conduct and support research, demonstration projects, evaluations, training, guideline development and the dissemination of information on health care services and delivery systems, including activities on: (1) the effectiveness, efficiency, and quality of health care services; (2) the outcomes of health care services and procedures; (3) clinical practice, including primary care and practice-oriented research; (4) health care technologies, facilities and equipment; (5) health care costs, productivity and market forces; (6) health promotion and disease prevention; (7) health statistics and epidemiology; and (8) medical liability.

IMPACT OF MEDICARE FEE SCHEDULE

The Medicare Fee Schedule was designed to remove many of the inequities of the previous payment system by shifting payment away from tests and procedures toward evaluation and management services. Because the fee schedule was intended to be implemented in a budget-neutral fashion, total outlays under the new system were expected to match the outlays that would have occurred under the previous payment system. In general, under the new payment system, primary care physicians were expected to receive higher payments per service, and specialty physicians were expected to receive lower payments per service.

The overall payment level under the Medicare Fee Schedule is established through the conversion factor. In effect, the conversion factor translates the relative value units for individual procedures into actual dollar payments. Increases or decreases in the overall level of payments are accomplished by adjusting the level of the conversion factor. In moving from the former payment system to the fee schedule, DHHS was required to set the initial conversion factor in a budget-neutral manner. Inaccuracies in setting the conversion factor could result in either underpayment to physicians or in excess outlays by the Medicare program. This calculation of the conversion factor required DHHS to make a number of important assumptions regarding both the number and type of services that would be provided. Of particular importance was the projected increase in the volume and intensity of services in response to changes in payment rates. The Department contended that past experience suggested that implementation of the new payment system would be accompanied by increases in volume and intensity of services. To account for these increases, DHHS made a "baseline adjustment" in the conversion factor.

Using data from 1991, 1992, and 1993, PhysPRC has examined the initial impact of the Medicare Fee Schedule on physicians. Table E-4 shows the change in Medicare payment to physicians between 1991 and 1993, by specialty. Changes in payment measured from 1991 to 1993 reflect four aspects of payment reform: two years of transition to the Medicare Fee Schedule, the uniform update for 1992, the differential update for surgical and nonsurgical services for 1993, and refinements to the relative values for 1993.

From 1991 to 1993, physicians' payments per service declined by 4 percent. Surgical specialties had about an 8 percent reduction in payment per service compared with the 2 percent increase for medical specialties. Specialties that predominantly provide evaluation and management services fared better. Payments to general and family practitioners increased by 17 percent over the two-year period, while those to internists rose by 2 percent. Pathologists and thoracic surgeons had the largest reduction of 16 percent, followed by gastroenterologists, radiologists, and cardiologists with reductions ranging from 10 percent to 12 percent.

The total Medicare payment a physician receives depends not only on the payment per service but also on changes in the number and intensity of services billed. Although physicians had about a 4 percent reduction in payment overall, a 6 percent increase in the number and intensity of services per physician led to about a 4 percent increase in total Medicare payment per physician over the 2-year period.

While payment rates to a majority of specialties fell, on average, most of these specialties provided more services. These increases, however, did not completely offset the reductions for most surgical specialties which had net reductions in Medicare payment. With restrictions on balance billing and higher participation rates, most surgical specialties had total reductions in Medicare revenue ranging from 6 percent to 12 percent over the 2-year period. Only urologists saw no change from 1991 to 1993. With increases in both payment per service and the number of services provided, family and general practitioners saw total Medicare payment increase by 23

percent from 1991 to 1993, while total Medicare revenue increased by 19 percent.

Using data from 1991 and 1993, PhysPRC also examined the initial impact of the Medicare Fee Schedule on physicians by state. Table E-5 shows the estimated change in Medicare payment rates by state and service category between 1991 and 1993. Overall, payment rates for all services declined by 3 percent from 1991 to 1993, while those for primary care services increased by 11 percent. Medicare payment rates for all services declined in all but 13 states. In contrast, payment rates for primary care services increased in all but 4 states. Changes in payment rates for all services ranged from a 5 percent increase in Colorado to a 9 percent decrease in Alaska and Nevada. Payment rates for primary care services increased substantially in many states, with 19 states experiencing increases of 20 percent or more. Payment rate changes for primary care services ranged from a 32 percent increase in Mississippi to a 9 percent decrease in Alaska.

TABLE E-4.—CHANGE IN MEDICARE PAYMENT, BY SPECIALTY, 1991-93

[Percentage change]

Specialty	Medicare payment per service	Volume and intensity of services per physician	Medicare payment per physician	Medicare revenue per physician ¹
Medical	2	8	8	4
Cardiology	-10	19	8	4
Family/general practice	17	6	23	19
Gastroenterology	-12	21	8	6
Internal medicine	2	-4	-2	-6
Other medical	0	19	16	12
Surgical	-8	4	-4	-8
General surgery	-6	4	-2	-6
Ophthalmology	-8	2	-8	-10
Orthopedic surgery	-8	4	-4	-10
Thoracic surgery	-16	10	-8	-12
Urology	-4	8	4	0
Other surgical	-2	4	2	-2
Radiology/Pathology	-12	16	2	0
Radiology	-12	15	0	0
Pathology	-16	32	10	6
All Physicians	-4	6	4	0

¹ Includes balance billing.

Note.—For these analyses, ER physicians were redesignated as general practitioners, which lead to substantial changes in estimates of payments per service for family and general practitioners and for internists. In addition, vascular surgeons were combined with general surgeons, while cardiac surgeons were combined with thoracic surgeons.

Source: Physician Payment Review Commission analysis of 1991 and 1993 Medicare claims, 5 percent sample of beneficiaries.

TABLE E-5.—ESTIMATED PERCENT CHANGE IN MEDICARE PAYMENT RATES, BY STATE AND CATEGORY OF SERVICE, 1991-93

State	All services	Primary care services	Other services
Alabama	-1	14	-5
Alaska	-9	-9	-9
Arizona	-6	-3	-7
Arkansas	-3	21	-8
California	-6	0	-7
Colorado	5	21	2
Connecticut	-5	0	-6
Delaware	0	16	-4
District of Columbia	-3	6	-5
Florida	-7	1	-9
Georgia	-2	19	-6
Hawaii	-6	-3	-8
Idaho	2	21	-2
Illinois	-2	15	-6
Indiana	-1	19	-6
Iowa	3	28	-1
Kansas	-1	21	-5
Kentucky	1	23	-3
Louisiana	-3	23	-8
Maine	0	18	-5
Maryland	-5	7	-8
Massachusetts	-3	2	-4
Michigan	1	21	-3
Minnesota	1	24	-3
Mississippi	4	32	-1
Missouri	-1	17	-4
Montana	-1	17	-4
Nebraska	-1	21	-5
Nevada	-9	-6	-10
New Hampshire	4	27	-1
New Jersey	0	17	-3
New Mexico	-2	15	-7
New York	-2	8	-4
North Carolina	0	18	-4
North Dakota	-1	19	-5
Ohio	-3	11	-6
Oklahoma	-1	17	-4
Oregon	1	13	-2
Pennsylvania	-3	12	-6
Puerto Rico and Virgin Islands	-5	1	-7

TABLE E-5.—ESTIMATED PERCENT CHANGE IN MEDICARE PAYMENT RATES, BY STATE AND CATEGORY OF SERVICE, 1991-93—Continued

State	All services	Primary care services	Other services
Rhode Island	0	17	-4
South Carolina	2	28	-3
South Dakota	-1	19	-4
Tennessee	0	21	-4
Texas	-2	20	-6
Utah	4	28	-1
Vermont	2	22	-4
Virginia	1	20	-3
Washington	0	15	-3
West Virginia	-2	9	-5
Wisconsin	0	14	-3
Wyoming	4	21	0
All States	-3	11	-5

Note.—CPT codes for visit services were converted from 1991 to 1993 coding before calculating fee changes. Therapeutic radiology services and dialysis services were omitted due to difficulties calculating fees per unit of service.

Source: PPRC analysis of Medicare 1993 BMAD procedure file and 1993 5 percent beneficiary Standard Analytic File data. 1993 data are calculated from claims incurred in the first six months of 1993 only.

SELECTED FEE SCHEDULE ISSUES

Establishment of relative values. Relative value units (RVUs) for physician work were based primarily on work done by a Harvard University research team. DHHS used panels of carrier medical directors to review comments received on the values contained in the proposed regulations to fill gaps in the Harvard relative value scale (RVS), and to resolve identified anomalies.

In recognition of that fact that further refinements might be necessary, DHHS designated the relative work values implemented on January 1, 1992 as "initial" values. Final RVUs for existing procedure codes under the fee schedule and interim RVUs for new and revised codes were issued in November 1992 and again in December 1993.

Due to changes in RVUs for codes reviewed as part of the refinement process, the addition of new codes to the fee schedule, and the revisions in payment policies, DHHS determined that net increases would have added a projected \$45 million in expenditures in calendar year 1994. Because certain revisions to the fee schedule are to be made in a budget-neutral manner, a uniform adjustment factor of -1.3 percent was added to all RVUs for 1994. This budget-neutral adjustment factor is the sum of two different adjustment factors that were necessary. The \$45 million that would have been added to Medicare payments required an adjustment to all RVUs of -0.1 percent to ensure budget neutrality. Two additional OBRA

1993 changes, elimination of electrocardiogram (EKG) reductions and new physician reductions, required an adjustment to all RVUs of - 1.2 percent to ensure budget neutrality for these issues.

OBRA 1993 required that an adjustment be made to practice expense RVUs for services for which practice expense RVUs exceed 128 percent of the corresponding work RVUs (and whose services are performed less than 75 percent of the time in an office setting). For services meeting these criteria, the 1994 practice expense RVUs were reduced by 25 percent of the amount by which the practice expense RVUs exceed the 1994 work RVUs. In 1995 and 1996, the excess, as determined for 1994, will be reduced an additional 25 percent each year. Practice expense RVUs will not be reduced to an amount less than 128 percent of the 1994 work RVU for a service. Certain services that are provided in office settings at least 75 percent of the time are exempt from cuts in practice expense RVUs.

Visit codes. Approximately one-third of Medicare expenditures for physicians' services are made for medical visits and consultations; these are referred to as evaluation and management services. Physicians bill for these services based on current procedure and terminology (CPT) codes developed by the American Medical Association (AMA).

Historically, there were wide variations in the way physicians used visit codes. To a degree, these differences could be accommodated under the old reasonable charge payment system. However, uniform definitions were needed under the new fee schedule. This is because a single relative value is assigned to each code nationwide.

The CPT editorial panel adopted new definitions and new code numbers for all visit categories, effective January 1, 1992. The physician work relative value units are based on these new definitions. The new definitions rely primarily on the clinical content of the visit to differentiate among levels of care. Most codes also indicate the typical amount of time spent by a physician in performing the service; this is an ancillary factor in code selection.

PhysPRC's analysis of claims data for all of 1992 and the first half of 1993 reveals some important successes concerning the new coding system. Physicians appear to be using the new codes in a more discriminating fashion. For all classes of visits (for example, office visit with a new patient) fewer physicians used only one level of service in coding, and more physicians used all the levels of service. The most substantial improvements came in hospital visits. Tracking the average level of service within classes of visits over the first six quarters demonstrated stable patterns of coding over time.

Global surgery policy. Medicare carriers have typically bundled payment for services associated with a surgery into one code, which is referred to as a global surgical service. Historically, there have been differences among carriers in the scope and duration of services included in the global surgery payment.

A uniform global surgery policy has been in effect since January 1992. The services included in the package are all preoperative services provided on the day before the surgery, all intraoperative services that are a normal and necessary part of the surgical proce-

ture, and all related services provided during a 90-day postoperative period (with the exception of services provided in connection with return trips to the operating room). The initial consultation with the surgeon is outside the global surgical package.

Specific rules also apply for minor surgeries and endoscopies. No payment will generally be made for a visit on the same day as the procedure unless a separately identifiable service is furnished. A zero or 10 day postoperative period applies for minor surgeries. (Those with a 10 day period are listed in an addendum to the final regulations.) There is no postoperative period for endoscopies performed through an existing body orifice. Other endoscopies are subject to either the major or minor surgical service policy, whichever is appropriate.

Anesthesia services. For several years, payments to anesthesiologists were made on the basis of a fee schedule which predated the RBRVS fee schedule. This anesthesia fee schedule used a separate set of relative values, known as the relative value guide, for anesthesia services which were developed by the American Society of Anesthesiology. Generally, the number of relative value units was the sum of base units and time units.

Generally, the allowable base units from the relative value guide were used when anesthesia services were integrated into the overall fee schedule. Unlike the policy for other services, DHHS temporarily retained the use of actual time in the final regulations; this was done pending further study of the issue. The retention of actual time requires that anesthesia services have a separate conversion factor. The anesthesia conversion factor in 1994, which reflects updates and budget neutrality adjusters, is \$14.20.

Anesthesia services may be performed directly by the anesthesiologist, by a certified registered nurse anesthetist (CRNA) under the medical direction of an anesthesiologist or by a nonmedically directed CRNA. If a physician personally performs the anesthesia service, payment is based on the anesthesia-specific conversion factor and unreduced base units and time units with each time unit equivalent to 15 minutes. If a physician medically directs an anesthesia service on or after January 1, 1994, the allowance is 60 percent of the allowance for the same service personally performed by the anesthesiologist. This percentage is reduced each year so that beginning January 1, 1998, it is 50 percent.

The allowance for an anesthesia service furnished by a medically directed CRNA on or after January 1, 1994 is calculated at 60 percent of the allowance for the same service personally performed by the anesthesiologist. This percentage is reduced each year so that beginning January 1, 1998, it is 50 percent. Anesthesia services furnished by a nonmedically directed CRNA are calculated based on allowable base and time units, the same as for anesthesia services personally furnished by an anesthesiologist, and a statutorily mandated national conversion factor, that is geographically adjusted. The nonmedically directed conversion factor is limited by the physician anesthesia conversion factor for the same payment area.

Beginning in 1994, the allowance for the teaching anesthesiologist's involvement in a single anesthesia case with an anesthesia intern or resident is determined in the same manner as the allow-

ance for the anesthesia service personally furnished by the nonteaching anesthesiologist.

Radiology services. Prior to 1992, radiology services performed by radiologists (or physicians for whom radiology services accounted for at least 50 percent of their Medicare billings) were paid under a radiology fee schedule. The relative values were based on values developed by the American College of Radiology. In 1992, as required by law, the radiologist fee schedule was integrated into the overall physician fee schedule. Prior relationships among radiology services were preserved, while appropriate modifications were made to develop consistent relationships between the physician work involved in radiology services and all other physician services. The work, practice expense, and malpractice RVUS were integrated separately.

Special payment rules apply to certain categories of radiology services. For portable x-ray services, national relative value units have been established which reflect equipment set-up costs per procedure. Associated transportation costs will continue to be priced locally.

The use of complete procedure codes has been discontinued for interventional radiological services; this is consistent with CPT changes. Payment of the full fee schedule amount is made for the radiological portion (supervision and interpretation code) of an interpretive radiologic service and for the primary nonradiologic service (the surgical code). For any other procedure codes, a reduction applies.

Payments for electrocardiograms (EKGs). For the 1994 fee schedule, separate payment for EKG interpretations performed in conjunction with visits and consultations is restored. (Separate payment had been barred since January 1, 1992.) The RVUs for visits and consultations will be reduced by the number of RVUs that were added to account for EKG interpretations. To ensure budget neutrality, a 0.3 percent reduction will be made to all RVUs including EKGs, visits, and consultations. (The 0.3 percent reduction corrects an error made in HCFA's original calculation in adding EKG RVUs to visit and consultation RVUs.) To ensure the provision is budget neutral throughout the remainder of the transition to the physician fee schedule, HCFA will reduce the 1994 transition payment amount by 0.7 percent.

New physicians. Prior to January 1, 1994, new physicians were paid at a reduced rate for the first four years of practice. This policy did not apply to primary care services or services furnished in health manpower shortage areas. This policy was first incorporated in OBRA 1987; it was subsequently expanded and modified by OBRA 1989 and OBRA 1990. The payment adjustment was rescinded by OBRA 1993, so Medicare payments for services furnished by new physicians and practitioners are now the same as payments made for the same services furnished by established physicians. To maintain budget neutrality, a 0.9 percent reduction was applied to all fee schedule RVUs and transition amounts for physician services (but not anesthesia services), anesthesia conversion factors, and the prevailing charge or fee schedule amount for practitioner services.

Physician pathology services. A limited number of the services listed in the pathology section of the CPT are identified as physician pathology services. The remainder are generally clinical diagnostic laboratory services which are paid under a separate fee schedule.

The law requires an adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from a physician's office. DHHS set the technical component at 15 percent of the professional component amount. DHHS also identified a new category of services—clinical laboratory interpretation services. Fifteen clinical laboratory codes have been identified for which a separate payment may be made if the interpretation is requested by the patient's attending physician, results in a written narrative report, and requires exercise of medical judgment by the pathologist.

Defining geographic payment localities. Under the reasonable charge system, Medicare used 240 payment localities nationwide. These payment localities have been retained under the fee schedule except in five States (Nebraska, North Carolina, Ohio, Oklahoma, and Minnesota) where physicians demonstrated overwhelming support for using statewide localities. There are currently 217 payment localities under the fee schedule.

OBRA 1989 required PhysPRC to conduct a study to determine the feasibility of using an alternative configuration, such as States or metropolitan statistical areas, for payment purposes under the fee schedule. PhysPRC recommended use of statewide fee schedule areas except in States with high intrastate price variation; in these States, up to five areas would be defined. DHHS is examining this and other recommendations. A change in the current locality structure would require a statutory change.

PAYMENT FOR CLINICAL LABORATORY SERVICES

Since 1984, payment for clinical laboratory services has been made on the basis of a fee schedule established on a regional, statewide or carrier service area basis. As a matter of practice, the Secretary has established fee schedules on a carrier service area basis. The law set the initial fee schedule payment amount for services performed in physicians' offices or independent laboratories at the 60th percentile of the prevailing charge level established for the fee screen year beginning July 1, 1984. Similarly, the initial fee schedule payment amount for services provided by hospital-based laboratories serving hospital outpatients was set at the 62nd percentile of the prevailing charge level. Subsequent amendments limited the percentage differential to "qualified hospitals." A qualified hospital is a sole community hospital (as that term is used for payment under Medicare's hospital prospective payment system) which provides some clinical diagnostic tests 24 hour a day in order to serve a hospital emergency room which is available to provide services 24 hours a day, 7 days a week.

The fee schedule payment amounts have been increased periodically since 1984 to account for inflation, though scheduled increases have in some instances been delayed and in one case did not occur. Allowable annual increases in 1991, 1992, and 1993 are limited to

2 percent. Allowable annual increases in 1994 and 1995 would be 0 percent.

Effective April 1, 1988, the law reduced the fee schedule amounts by 8.3 percent for certain automated tests and tests (except for cytopathology tests) that were subject to lowest charge level limits prior to implementation of the fee schedule. The reduced payment amounts serve as the basis for all future updates for these services.

Beginning in 1988, the law established *national ceilings* on payment amounts. Initially the ceiling was set at 115 percent of the median for all fee schedules established for that test. This percentage has been lowered several times. Beginning January 1, 1991, the level is set at 88 percent of the median of all fee schedules for that test. The national ceiling on payment amounts would be lowered to 84 percent beginning January 1, 1994, 80 percent beginning January 1, 1995 and 76 percent beginning January 1, 1995.

Payment for clinical laboratory services (except for those provided by a rural health clinic) may only be made on the basis of assignment. The law specifically applies the assignment requirement to clinical laboratory services provided in physicians offices. Payment for clinical laboratory services equals 100 percent of the fee schedule amount; no beneficiary cost-sharing is imposed.

Laboratories are required to meet the requirements of the Clinical Laboratory Improvement Act (CLIA). This legislation, which focuses on the quality and reliability of medical tests, was substantially revised in 1988 (CLIA 1988). CLIA 1988 strengthened Federal regulation of laboratories and expanded Federal oversight to virtually all laboratories in the country, including physicians office laboratories. Implementing regulations were issued February 28, 1992; technical and clarifying corrections were issued January 19, 1993.

HISTORICAL DATA

ASSIGNMENT RATE EXPERIENCE

The total number of assigned claims as a percentage of total claims received by medicare carriers for physicians and other medical services is known as the total assignment rate. Initially, the net assignment rate was computed in the same manner except that it omitted hospital-based physicians and group-practice prepayment plans which were considered assigned by definition (this distinction is no longer made). The net assignment rate declined until the mid-1970's when the rate leveled off at about 50 percent. Since 1985, the rate has increased significantly rising to 89.2 percent in 1993. This reflects both the impact of the participating physician program as well as the requirement that laboratory services must be paid on an assigned basis. Chart E-1 and table E-6 show the net assignment rates for fiscal years 1969-93.

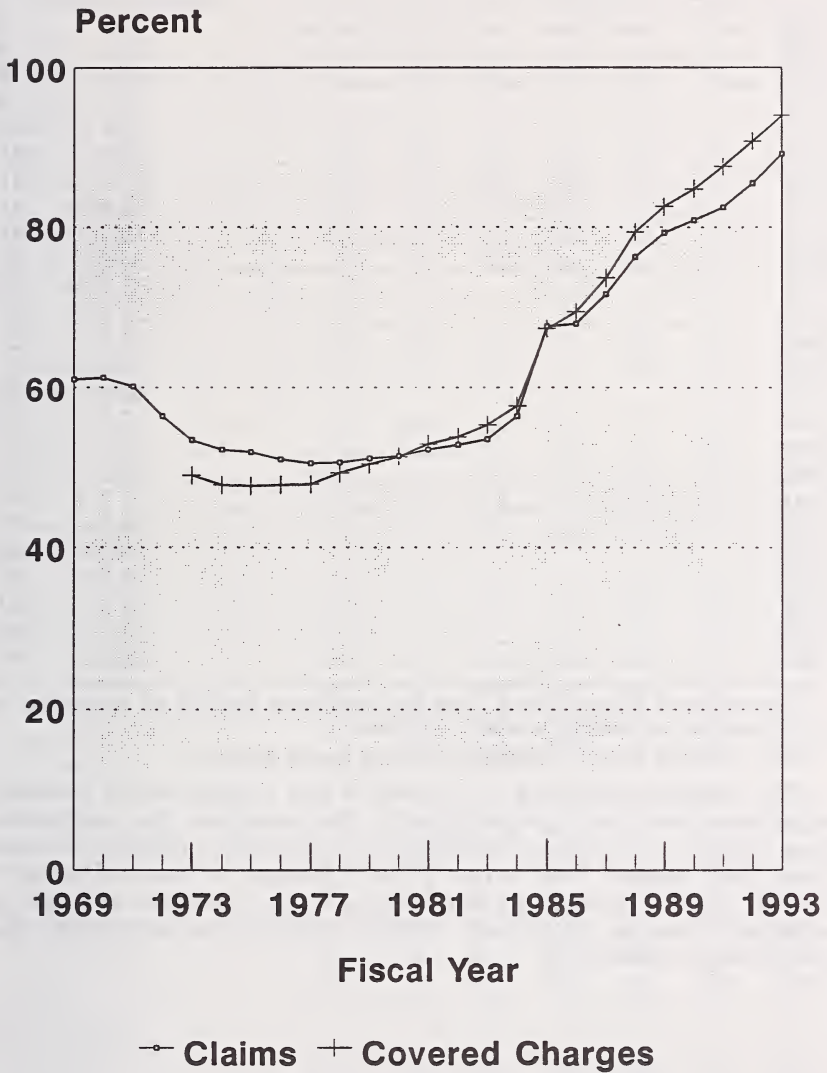
CHART E-1. NET ASSIGNMENT RATES (1969-1993)

TABLE E-6.—NET ASSIGNMENT RATES,¹ BY YEAR, 1969-93

[In percent]

Fiscal year	Claims	Covered charges
1969	61.0	NA
1970	61.2	NA
1971	60.1	NA
1972	56.4	NA
1973	53.4	49.0
1974	52.2	47.8
1975	51.9	47.7
1976	51.0	47.8
1977	50.5	47.9
1978	50.6	49.3
1979	51.1	50.4
1980	51.4	51.3
1981	52.2	52.9
1982	52.8	53.8
1983	53.5	55.3
1984	56.4	57.7
1985	67.7	67.4
1986	68.0	69.5
1987	71.7	73.7
1988	76.3	79.4
1989	79.3	82.6
1990	80.9	84.8
1991	82.5	87.6
1992	85.5	90.8
1993	89.2	94.0

¹ Both measures of assignment exclude claims from hospital-based physicians and group-practice prepayment plans that are considered assigned by definition.

Source: Health Care Financing Administration, Bureau of Program Operations.

The statistics included in table E-6 are program-wide data. Assignment rates vary geographically. For example, the assignment rate (taken as a percent of dollars) for physician services in fiscal year 1993 ranged from a low of 50.2 percent in South Dakota to a high of 99.8 percent in Rhode Island. The national average assignment rate for physicians services during this period was 93.2 percent (see table E-7).

TABLE E-7.—PHYSICIAN ASSIGNMENT RATES AS PERCENT OF ALLOWED CHARGES, BY STATE, FOR SELECTED YEARS ¹

[In percent]

Census division/State	Fiscal year—						
	1985	1987 ²	1989	1990	1991	1992	1993
National	65.5	70.8	80.6	83.0	86.1	89.4	93.2
New England:							
Maine	81.5	84.3	91.4	92.4	94.4	96.7	98.0
New Hampshire	56.5	58.3	67.8	69.9	80.8	89.4	93.9
Vermont	64.3	71.7	93.4	94.7	95.9	97.8	98.6
Massachusetts ³	93.7	98.2	99.3	99.5	99.5	99.6	99.7
Rhode Island	94.0	95.1	97.1	98.7	99.7	99.7	99.8
Connecticut	57.6	62.8	80.4	84.7	87.7	91.7	94.7
Middle Atlantic:							
New York	70.3	73.9	81.1	81.9	84.4	87.7	90.7
New Jersey	62.3	63.8	70.4	73.0	76.3	80.5	85.4
Pennsylvania	88.1	91.0	94.9	95.7	98.5	99.1	99.4
East North Central:							
Ohio	50.8	58.8	77.8	82.6	87.3	92.5	97.7
Indiana	49.6	59.2	74.7	77.2	81.5	85.7	92.9
Illinois	51.7	59.9	72.4	75.9	78.8	83.2	89.2
Michigan	88.2	89.7	93.6	94.5	94.4	95.9	97.8
Wisconsin	51.7	54.6	65.6	68.2	71.7	78.2	86.8
West North Central:							
Minnesota	30.6	39.9	46.1	47.6	52.3	57.1	67.1
Iowa	46.9	53.2	67.5	69.8	73.4	78.8	85.6
Missouri ⁴	50.1	61.2	72.3	74.9	78.5	83.7	91.6
North Dakota	30.5	36.3	50.3	55.0	67.1	72.1	74.9
South Dakota	18.7	26.7	38.7	39.2	40.2	43.3	50.2
Nebraska	47.3	43.4	59.6	64.9	70.3	76.8	83.8
Kansas ⁵	72.7	78.7	87.2	88.8	91.9	94.5	96.2
South Atlantic:							
Delaware	81.8	81.9	88.1	90.5	92.9	95.2	96.8
Maryland ⁶	81.6	84.6	91.6	91.4	92.8	94.3	96.7
District of Columbia ⁷	78.1	80.5	86.5	87.5	89.4	92.1	94.1
Virginia ⁸	66.4	73.4	85.1	87.3	89.6	92.5	95.7
West Virginia	66.7	76.9	90.3	93.2	95.5	97.2	98.4
North Carolina	60.3	66.2	79.2	80.8	83.9	88.8	93.7
South Carolina	64.9	75.4	85.8	87.1	88.9	91.6	94.4
Georgia	63.9	69.1	80.5	83.5	86.6	90.3	94.0
Florida	62.2	68.6	80.3	84.1	87.6	91.0	95.0
East South Central:							
Kentucky	50.3	63.5	80.8	84.8	88.8	91.9	95.5
Tennessee	55.6	65.5	80.9	84.0	89.5	93.1	96.3
Alabama	74.6	91.7	90.1	92.3	94.9	96.6	98.0
Mississippi	63.5	73.5	85.4	88.1	90.6	93.1	95.6
West South Central:							
Arkansas	72.6	81.1	90.3	92.0	93.7	95.4	96.6
Louisiana	51.0	67.8	84.8	88.0	91.0	93.8	95.2
Oklahoma	39.0	48.6	66.0	68.2	72.8	77.8	85.0
Texas	63.0	67.2	78.0	79.9	83.0	87.4	91.6

TABLE E-7.—PHYSICIAN ASSIGNMENT RATES AS PERCENT OF ALLOWED CHARGES, BY STATE, FOR SELECTED YEARS ¹—Continued

[In percent]

Census division/State	Fiscal year—						
	1985	1987 ²	1989	1990	1991	1992	1993
Mountain:							
Montana	42.6	42.9	50.7	53.0	54.8	61.3	72.7
Idaho	25.2	26.4	33.7	36.1	40.2	40.1	54.1
Wyoming	33.8	30.4	40.2	43.9	48.9	57.5	69.0
Colorado	56.0	56.8	67.6	70.4	74.1	79.7	86.8
New Mexico	58.3	57.6	71.7	76.1	80.1	84.9	91.5
Arizona	52.8	57.1	72.0	76.2	80.3	84.4	89.6
Utah	63.1	69.4	79.9	80.4	83.1	88.4	92.8
Nevada	81.6	86.8	94.4	96.0	97.4	98.4	99.0
Pacific:							
Washington	45.5	46.6	50.8	54.8	60.8	69.2	74.3
Oregon	38.7	46.9	58.4	59.9	63.2	69.3	82.1
California	71.3	74.0	87.7	84.4	87.4	90.2	93.8
Alaska	54.4	64.3	78.5	79.6	83.2	89.1	93.9
Hawaii	61.2	72.0	80.7	82.9	85.8	93.1	96.1

¹ Rates reflect covered charges for physician claims processed during the period.² The actual participation period was January 1987 through March 1988, and the participation agreements were in effect for that time.³ Massachusetts enacted a Medicare mandatory assignment provision, effective April 1986. The fact that the assignment rates shown here are not 100 percent may be explained by the inclusion in the data base of billings by practitioners other than allopathic and osteopathic physicians, which are included in the Medicare statutory definition of "physician".⁴ For fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.⁵ For fiscal year 1993, includes data for all counties in Kansas excluding two counties on the State border.⁶ For fiscal year 1993, includes data for all counties in Maryland excluding two counties on the State border.⁷ For fiscal year 1993, includes data for DC plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia, near the State border.⁸ For fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Health Care Financing Administration, Bureau of Program Operations.

PARTICIPATING PHYSICIAN PROGRAM DATA

Physician participation rates have increased significantly since the inception of the program (see tables E-8 and E-9). For the calendar year 1993 participation period, the physician participation rate (including limited licensed practitioners) had risen to 59.8 percent accounting for 85.5 percent of allowed charges for physician services during the period.

TABLE E-8.—MEDICARE PHYSICIAN PARTICIPATION RATES: PERCENT OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS WITH AGREEMENTS AND THEIR SHARE OF ALLOWED CHARGES, 1984–1993

Participation period	Percent of physicians signing agreements	Participating physicians' covered charges as a percent of total ¹
October 1984–September 1985	30.4	36.0
October 1985–April 1986	28.4	36.3
April 1986–December 1986 ²	28.3	38.7
January 1987–March 1988	30.6	48.1
April 1988–December 1988	37.3	57.9
January 1989–March 1990	40.2	62.0
April 1990–December 1990	45.5	67.2
January 1991–December 1991	47.6	72.3
January 1992–December 1992	52.2	78.8
January 1993–December 1993	59.8	85.5

¹ Rates reflect covered charges for physician services processed during period.

² The actual participation period was May through December of 1986, and participation agreements were in effect for that time. However, charge data are generally collected by quarter; thus, the data for the last three quarters of 1986 are used as a proxy for the participation period.

Source: Health Care Financing Administration, Bureau of Program Operations.

Table E-10 shows the percentage of participating physicians and limited licensed practitioners as a percentage of total physicians and limited licensed practitioners for each State. The national average of participating physicians and limited licensed practitioners continues to increase. By the calendar year 1993 participation period, this percentage had risen to 59.8.

TABLE E-9.—PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS, BY SPECIALTY, FOR SELECTED PARTICIPATION PERIODS

Specialty	Oct. 1985– Apr. 1986	Jan. 1987– Mar. 1988	Jan. 1989– Mar. 1990	Apr. 1990– Dec. 1990	Jan. 1991– Dec. 1991	Jan. 1992– Dec. 1992	Jan. 1993– Dec. 1993
Physicians (M.D.s and D.O.s):							
General practice	27.3	25.6	35.8	39.7	44.0	48.0	55.1
General surgery	33.9	37.2	52.2	55.8	60.5	66.3	73.8
Otology, laryngology, rhinology	24.6	27.0	41.2	45.2	49.6	57.0	66.2
Anesthesiology	21.1	20.3	28.3	30.8	36.5	49.3	64.6
Cardiovascular disease	35.6	43.2	55.5	60.6	65.4	72.0	78.7
Dermatology	34.0	38.1	48.7	53.4	57.0	61.6	69.8
Family practice	25.5	27.1	39.7	47.2	50.8	57.7	66.1
Internal medicine	32.5	33.6	45.2	48.8	52.6	57.8	66.2
Neurology	34.8	39.2	49.2	53.1	56.1	63.8	71.8
Obstetrics-gynecology	29.1	31.5	44.2	48.8	52.6	58.0	65.7
Ophthalmology	27.3	35.1	50.5	55.6	60.0	66.1	73.2
Orthopedic surgery	29.0	32.6	49.2	53.7	58.4	65.5	74.9
Pathology	39.6	41.2	50.6	53.4	59.2	65.8	73.3
Psychiatry	30.0	28.6	37.8	41.6	44.1	48.8	53.5
Radiology	41.3	39.8	49.6	55.6	62.0	68.2	74.7
Urology	27.8	30.9	45.6	49.6	53.6	61.7	71.8
Nephrology	50.8	49.7	60.0	66.5	71.7	76.3	82.4
Clinic or other group practice—not GPPP	33.8	50.6	67.8	68.7	73.9	77.0	75.5
Other medical specialties	32.4	30.1	.....	.....	.....	.....	.....
Other surgical specialties	18.2	14.8	.....	.....	.....	.....	.....
Other physicians .....	.....	.....	.....	29.2	.....	35.9	50.5
Total physicians .....	.....	.....	.....	45.5	49.6	55.3	63.5

Limited license practitioners (LLP):

Chiropractor	25.4	19.7	24.8	26.2	28.6	31.4	35.6
Podiatry-surgical chiropody	38.2	33.4	52.6	54.0	59.6	64.2	70.9
Optometrist	44.0	44.1	48.9	54.0	56.9	59.0	62.7
Other limited license practitioners (audiologist, psychologist, physical therapist)	36.8	30.9	35.3	38.4	36.4	35.8	43.9
Certified registered midwife .....	.....	.....	.....	15.2	23.8	40.7	51.0
Certified registered nurse anesthetist .....	.....	.....	.....	12.5	26.3	31.3	43.8
Total limited license practitioners .....	.....	.....	.....	40.0	40.0	41.0	47.4
Suppliers:							
Independent laboratory	28.4	37.2	20.1	45.4	49.7	52.4	55.4
Durable medical equipment suppliers	22.7	16.6	30.1	21.7	23.1	24.2	30.8
Ambulance service suppliers	28.6	27.9	43.8	32.1	32.3	34.4	36.4
Miscellaneous suppliers (orthotists, prosthetists, portable x ray suppliers)	22.5	15.5	17.5	17.5	17.7	18.2	25.7
Total supplies .....	.....	.....	.....	21.8	22.6	23.7	29.5

Source: Health Care Financing Administration, Bureau of Program Operations.

TABLE E-10.—PHYSICIAN AND LIMITED LICENSED PRACTITIONER PARTICIPATION RATES AS PERCENTAGE OF PHYSICIANS AND LIMITED LICENSED PRACTITIONERS, BY STATE, FOR SELECTED PARTICIPATION PERIODS

State	Oct. 1985– Apr. 1986		Jan. 1987– Mar. 1988		Jan. 1989– Mar. 1990		Apr. 1990– Dec. 1990		Jan. 1991– Dec. 1991		Jan. 1992– Dec. 1992		Jan. 1993– Dec. 1993	
Alabama	58.2	68.8	75.9	74.6	82.7	83.4	85.1	85.1	85.1	85.1	85.1	85.1	85.1	85.1
Alaska	10.4	27.1	38.8	48.0	53.8	55.1	60.4	60.4	60.4	60.4	60.4	60.4	60.4	60.4
Arizona	15.4	28.1	41.2	53.5	61.3	64.5	76.2	76.2	76.2	76.2	76.2	76.2	76.2	76.2
Arkansas	45.2	42.0	53.1	53.9	59.9	57.8	62.1	62.1	62.1	62.1	62.1	62.1	62.1	62.1
California	30.0	38.9	54.0	57.7	60.8	62.6	65.9	65.9	65.9	65.9	65.9	65.9	65.9	65.9
Colorado	28.1	19.5	28.1	33.9	35.3	48.0	55.7	55.7	55.7	55.7	55.7	55.7	55.7	55.7
Connecticut	22.2	17.4	29.3	32.8	40.8	48.1	55.4	55.4	55.4	55.4	55.4	55.4	55.4	55.4
Delaware	23.9	31.2	37.5	42.5	43.9	51.9	57.4	57.4	57.4	57.4	57.4	57.4	57.4	57.4
District of Columbia	30.5	28.0	34.4	37.9	39.8	45.9	50.6	50.6	50.6	50.6	50.6	50.6	50.6	50.6
Florida	25.7	24.9	32.8	34.4	36.5	41.5	55.6	55.6	55.6	55.6	55.6	55.6	55.6	55.6
Georgia	33.1	25.8	49.7	49.5	53.6	57.2	74.9	74.9	74.9	74.9	74.9	74.9	74.9	74.9
Hawaii	20.6	47.8	53.7	56.8	57.3	64.1	75.9	75.9	75.9	75.9	75.9	75.9	75.9	75.9
Idaho	11.0	10.4	16.0	17.3	19.5	22.9	37.1	37.1	37.1	37.1	37.1	37.1	37.1	37.1
Illinois	23.1	26.7	40.0	42.3	46.9	50.8	57.6	57.6	57.6	57.6	57.6	57.6	57.6	57.6
Indiana	18.2	26.9	40.0	42.6	45.1	49.3	55.8	55.8	55.8	55.8	55.8	55.8	55.8	55.8
Iowa	29.7	25.1	45.3	48.1	51.9	58.8	61.8	61.8	61.8	61.8	61.8	61.8	61.8	61.8
Kansas	45.4	51.4	61.6	57.1	62.6	70.3	73.2	73.2	73.2	73.2	73.2	73.2	73.2	73.2
Kentucky	24.3	34.2	50.5	56.4	59.5	64.0	73.6	73.6	73.6	73.6	73.6	73.6	73.6	73.6
Louisiana	18.8	18.1	32.6	34.6	42.9	44.6	44.0	44.0	44.0	44.0	44.6	44.0	44.0	44.0
Maine	35.4	34.2	51.2	48.7	50.3	51.6	52.0	52.0	52.0	52.0	51.6	52.0	52.0	52.0
Maryland	30.4	30.1	42.8	45.9	45.3	58.7	72.5	72.5	72.5	72.5	58.7	72.5	72.5	72.5
Massachusetts	48.1	43.8	46.9	50.5	50.8	50.0	50.2	50.2	50.2	50.2	50.0	50.2	50.2	50.2
Michigan	44.0	32.7	41.7	44.7	53.7	51.7	58.1	58.1	58.1	58.1	51.7	58.1	58.1	58.1
Minnesota	18.5	22.4	25.4	27.5	29.3	34.4	44.4	44.4	44.4	44.4	34.4	44.4	44.4	44.4
Mississippi	19.1	23.6	33.4	38.0	42.7	47.9	53.6	53.6	53.6	53.6	47.9	53.6	53.6	53.6
Missouri	35.2	24.5	39.6	45.7	49.0	51.8	67.5	67.5	67.5	67.5	51.8	67.5	67.5	67.5
Montana	24.3	17.0	21.5	23.4	24.8	23.7	54.7	54.7	54.7	54.7	23.7	54.7	54.7	54.7
Nebraska	20.0	25.7	42.5	49.2	56.5	61.1	70.6	70.6	70.6	70.6	61.1	70.6	70.6	70.6
Nevada	21.7	33.5	57.0	69.8	72.9	75.4	84.9	84.9	84.9	84.9	75.4	84.9	84.9	84.9

New Hampshire	26.9	25.9	28.0	30.9	32.7	38.5	43.0
New Jersey	18.0	22.7	26.0	27.6	29.6	36.5	42.6
New Mexico	17.7	30.8	36.3	45.6	49.7	53.6	66.8
New York	20.8	24.1	29.8	30.4	34.6	36.9	40.7
North Carolina	39.1	31.4	54.2	52.9	58.1	68.2	72.8
North Dakota	10.9	20.5	31.7	42.2	43.9	45.8	55.0
Ohio	21.7	28.9	46.8	50.8	52.5	57.3	76.6
Oklahoma	13.8	20.8	31.6	36.4	39.0	44.4	53.9
Oregon	18.5	26.1	36.9	41.7	46.7	51.7	59.2
Pennsylvania	50.8	32.1	39.0	42.1	45.9	53.0	59.7
Rhode Island	46.7	50.8	58.8	67.0	67.8	70.3	80.9
South Carolina	17.9	25.3	42.1	55.5	57.9	63.0	67.3
South Dakota	8.0	12.7	20.0	19.6	20.6	23.7	31.6
Tennessee	21.1	43.4	57.6	58.4	63.7	67.6	70.5
Texas	19.7	19.4	28.9	36.4	38.9	52.9	61.3
Utah	29.3	42.2	54.7	65.1	65.6	69.5	80.3
Vermont	41.5	34.1	40.5	43.8	45.4	54.2	56.5
Virginia	29.6	33.6	40.9	46.0	48.1	49.7	52.2
Washington	23.6	26.9	31.4	34.7	46.1	53.1	64.7
West Virginia	22.9	37.5	59.1	63.2	66.3	68.4	75.9
Wisconsin	31.0	35.1	40.0	46.5	46.8	55.5	66.8
Wyoming	18.3	20.3	19.3	34.6	39.1	50.2	53.3
National	28.4	30.6	40.7	44.1	47.6	52.2	59.8

Source: Health Care Financing Administration, Bureau of Program Operations.

Table E-11 shows the allowed charges of participating physicians as a percent of total allowed charges, by State, for several participation periods. This percentage increased substantially, rising from 36 percent in the October 1984 to September 1985 period to 85.5 percent in the calendar 1993 participation period.

TABLE E-1.1.—ALLOWED CHARGES OF PARTICIPATING PHYSICIANS AS A PERCENT OF TOTAL ALLOWED CHARGES, BY STATE, FOR SELECTED PARTICIPATION PERIODS¹

[In percent]

Census division/State	Oct. 1984— Sept. 1985	Jan. 1987— Mar. 1988 ²	Jan. 1989— Mar. 1990	Apr. 1990— Dec. 1990	Jan. 1991— Dec. 1991	Jan. 1992— Dec. 1992	Jan. 1993— Dec. 1993
National	36.0	48.1	62.0	67.2	72.3	78.8	85.5
New England:							
Maine	50.9	64.8	79.4	80.5	84.2	89.9	92.4
New Hampshire	40.1	36.0	42.8	46.2	68.3	80.7	88.1
Vermont	37.3	46.8	81.4	85.9	90.2	93.4	94.8
Massachusetts	70.7	89.1	95.4	95.0	96.7	96.3	95.9
Rhode Island	68.7	85.8	88.8	95.2	97.6	98.5	98.9
Connecticut	30.7	45.3	65.9	67.9	76.2	82.4	87.9
Middle Atlantic:							
New York	31.5	40.8	51.7	58.0	63.7	72.2	77.7
New Jersey	21.5	32.8	42.3	49.6	55.2	61.8	72.6
Pennsylvania	71.4	75.1	81.6	87.9	92.3	95.4	98.0
East North Central:							
Ohio	24.9	41.5	61.9	70.9	79.1	86.3	94.6
Indiana	18.9	43.3	60.6	65.2	70.2	80.9	89.1
Illinois	29.4	42.0	58.1	61.8	66.1	72.2	82.2
Michigan	55.4	71.9	85.6	86.0	86.5	92.0	95.1
Wisconsin	31.3	31.7	42.7	48.9	45.6	61.5	76.9
West North Central:							
Minnesota	9.9	14.6	20.2	25.4	28.6	35.5	49.5
Iowa	28.5	41.0	54.2	57.8	61.9	71.0	80.8
Missouri ³	26.7	37.5	41.8	40.1	40.4	45.3	67.7
North Dakota	6.9	16.0	32.3	45.5	53.2	61.2	65.8
South Dakota	3.2	10.4	19.5	21.2	21.1	24.6	36.0

TABLE E-11.—ALLOWED CHARGES OF PARTICIPATING PHYSICIANS AS A PERCENT OF TOTAL ALLOWED CHARGES, BY STATE, FOR SELECTED PARTICIPATION PERIODS ¹—Continued

[In percent]

Census division/State	Oct. 1984— Sept. 1985	Jan. 1987— Mar. 1988 ²	Jan. 1989— Mar. 1990	Apr. 1990— Dec. 1990	Jan. 1991— Dec. 1991	Jan. 1992— Dec. 1992	Jan. 1993— Dec. 1993
Nebraska	30.5	31.8	51.7	54.8	60.3	69.7	79.8
Kansas ⁴	48.0	NA	82.5	82.3	86.8	91.3	94.6
South Atlantic:							
Delaware	57.0	58.5	70.8	76.6	81.7	87.2	93.5
Maryland ⁵	57.8	67.4	80.4	83.3	85.6	86.4	87.1
District of Columbia ⁶	60.3	66.6	73.9	76.8	80.8	85.4	90.1
Virginia ⁷	31.0	53.0	69.5	71.2	78.4	84.1	90.9
West Virginia	34.5	59.3	77.5	80.6	85.2	90.0	93.4
North Carolina	34.4	44.9	55.2	63.9	68.3	82.4	87.1
South Carolina	29.9	55.2	68.5	67.6	71.6	79.3	86.6
Georgia	29.3	43.0	50.7	65.9	74.9	82.8	81.6
Florida	30.0	41.9	61.6	68.8	74.9	81.8	89.0
East South Central:							
Kentucky	22.3	44.7	64.3	72.6	76.9	84.3	90.7
Tennessee	25.1	41.3	57.4	68.5	76.8	86.8	91.8
Alabama	42.5	66.9	81.3	84.9	88.5	91.7	94.9
Mississippi	14.3	44.9	65.3	68.3	73.9	82.1	88.6
West South Central:							
Arkansas	47.9	68.3	81.0	84.5	86.5	90.0	93.4
Louisiana	16.2	48.2	71.0	76.7	81.2	86.6	89.4
Oklahoma	16.6	24.9	39.1	50.0	57.7	62.8	74.0
Texas	26.2	38.9	52.5	56.9	63.6	72.6	81.5
Mountain:							
Montana	25.6	23.8	29.9	29.7	34.1	42.7	58.9

Idaho	8.6	9.3	13.2	17.5	21.1	23.5	41.2
Wyoming	15.7	14.1	19.7	25.8	31.9	44.1	61.0
Colorado	23.5	34.0	47.7	50.5	55.9	63.5	76.4
New Mexico	34.1	28.1	39.5	51.1	57.8	64.9	78.2
Arizona	32.7	38.3	49.8	60.2	67.8	75.2	83.7
Utah	43.8	58.4	68.9	65.1	75.1	81.8	83.1
Nevada	41.5	63.4	69.9	82.1	87.5	92.3	96.0
Pacific:							
Washington	17.5	20.2	26.9	31.8	37.9	45.2	50.7
Oregon	17.3	25.5	34.8	43.3	50.7	59.8	73.6
California	42.2	50.2	67.2	71.2	75.6	80.0	86.6
Alaska	17.2	34.3	50.0	49.3	58.0	70.9	81.3
Hawaii	39.7	53.5	58.6	70.1	74.3	84.7	90.6

¹ Rates reflect covered charges for physician claims processed during the period.

² The actual participation period is January 1987 through March 1988, and the participation agreements were in effect for that time.

³ For fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.

⁴ For fiscal year 1993, includes data for all counties in Kansas excluding two counties on the State border.

⁵ For fiscal year 1993, includes data for all counties in Maryland excluding two counties on the State border.

⁶ For fiscal year 1993, includes data for DC plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia, near the State border.

⁷ For fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Health Care Financing Administration, Bureau of Program Operations.

PARTICIPATION, ASSIGNMENT, AND CHARGE REDUCTIONS

Historically the difference between the physician's billed charge and Medicare's approved or reasonable charge was referred to as the reasonable charge reduction. Beginning in 1992, with implementation of the fee schedule, the term reasonable charge reduction no longer applies. Instead, the term charge reduction refers to the difference between the physicians' billed charge and the fee schedule amount. Charge reductions were made on 85.5 percent of unassigned claims in fiscal year 1993. The average amount of the reduction was 16.9 percent of billed charges, or \$17.26 per approved claim. Beneficiaries were liable for these reduction amounts, although it is not known how often physicians actually collected from beneficiaries. The total reduced on all unassigned claims was \$797.5 million in fiscal year 1993.

Through 1984, approximately the same proportions of assigned and unassigned claims were reduced (see table E-12), and were reduced by similar proportions and amounts. From 1984 to 1993, the proportions of assigned and unassigned claims reduced remained about the same, but the percentage and amounts of the reductions diverged. The percent and dollar reductions on assigned claims continued to increase while the percent and dollar reductions of unassigned claims decreased. This pattern was due to the imposition of limits on the actual charges of nonparticipating physicians. That is, the MAAC limits, and the new balance billing limits beginning in 1991, limited the rate of increase in prices for unassigned services relative to the overall increase in reasonable charges. The substantial growth in the overall percentage of services billed on an assigned basis also may have contributed to this pattern.

As a result, total beneficiary liability for charge reductions on unassigned claims fell. Total liability peaked in 1985 at \$2,812.7 million, and declined to \$797.5 million by 1993.

TABLE E-12.—REASONABLE CHARGE REDUCTIONS FOR MEDICARE PART B (EXCLUDES CLAIMS FROM HOSPITAL-BASED PHYSICIANS AND GROUP-PRACTICE PREPAYMENT PLANS) FOR ASSIGNED AND NOT ASSIGNED CLAIMS, FISCAL YEARS 1975, 1980, AND 1985–1993

	1975	1980	1985	1986	1987	1988	1989	1990	1991	1992	1993
Percentage of claims reduced:											
Assigned	68.3	80.0	81.7	82.5	83.0	85.5	86.3	87.6	86.7	87.0	188.2
Not assigned	75.6	83.7	84.6	84.9	82.5	85.7	89.2	89.2	90.7	85.4	185.5
Percentage reduction in charges for covered services:											
Assigned	16.4	22.5	27.0	28.4	27.9	29.3	30.9	32.6	35.2	39.2	42.1
Not assigned	16.6	22.3	25.6	26.6	25.5	24.7	25.2	25.3	24.0	19.7	16.9
Amount reduced per approved claim:											
Assigned	\$11.13	\$21.81	\$33.19	\$36.43	\$36.98	\$39.97	\$43.72	\$48.22	\$54.20	\$63.60	\$79.49
Not assigned	\$13.45	\$21.96	\$33.12	\$33.15	\$31.44	\$29.47	\$29.67	\$28.97	\$24.84	\$18.95	\$17.26
Amount reduced on claims not assigned (in millions)	\$450.1	\$1,454.0	\$2,571.9	\$2,812.5	\$2,677.8	\$2,312.6	\$2,213.7	\$2,198.0	\$1,948.5	\$1,317.0	\$797.5

¹ Figure may be slightly overstated due to the possibility of a claim being counted more than once because more than one type of reduction is applied.

Source: Health Care Financing Administration, Bureau of Program Operations.

The impact of charge reductions on unassigned claims was spread unevenly across the population. Calendar 1993 data show a 16.4 percent national average reduction on unassigned claims (see table E-13). Beneficiary liability for these charge reductions ranged from a high of \$95.8 million in New York to a low of \$0.1 million in Rhode Island.

TABLE E-13.—CHARGE REDUCTIONS FOR UNASSIGNED CLAIMS, BY STATE,¹ JANUARY–DECEMBER, 1993

[Dollar amounts in millions]

Census division/State	Covered charges ²		Percent reduction in unassigned charges	Amount reduced, unassigned charges ²
	Total	Unassigned		
National	\$76,655.0	\$4,155.2	16.4	\$683.4
New England:				
Maine	333.0	6.3	15.3	1.0
New Hampshire	260.8	13.3	14.7	2.0
Vermont	120.7	1.9	15.9	0.3
Massachusetts ³	2,356.7	10.2	14.2	1.4
Rhode Island	369.2	1.5	9.1	0.1
Connecticut	1,267.8	51.9	14.6	7.6
Middle Atlantic:				
New York	6,201.3	495.1	19.3	95.8
New Jersey	2,911.8	312.1	16.6	51.9
Pennsylvania	5,821.7	36.3	15.0	5.4
East North Central:				
Ohio	3,345.0	44.4	19.4	8.6
Indiana	1,436.7	92.6	17.0	15.7
Illinois	2,953.0	251.2	17.0	42.6
Michigan	3,261.4	62.1	18.2	11.3
Wisconsin	1,143.0	126.6	14.7	18.6
West North Central:				
Minnesota	704.6	205.1	16.1	33.1
Iowa	647.3	79.8	14.5	11.6
Missouri ⁴	1,721.5	115.3	5.4	6.2
North Dakota	184.2	41.0	16.2	6.6
South Dakota	155.6	61.8	15.6	9.6
Nebraska	347.0	50.1	16.1	8.1
Kansas ⁵	528.4	18.0	14.4	2.6
South Atlantic:				
Delaware	243.8	6.5	14.6	0.9
Maryland ⁶	1,281.3	35.9	16.4	5.9
District of Columbia ⁷	1,015.6	49.9	17.9	9.0
Virginia ⁸	1,253.0	46.6	14.7	6.8
West Virginia	549.7	7.5	17.7	1.3
North Carolina	2,061.8	97.5	16.6	16.3
South Carolina	840.9	43.9	21.4	9.4
Georgia	1,794.9	79.7	20.5	16.4
Florida	7,204.7	272.2	18.6	50.5
East South Central:				
Kentucky	1,092.1	34.2	15.9	5.4

TABLE E-13.—CHARGE REDUCTIONS FOR UNASSIGNED CLAIMS, BY STATE,¹ JANUARY–DECEMBER, 1993—Continued

[Dollar amounts in millions]

Census division/State	Covered charges ²		Percent reduction in unassigned charges	Amount reduced, unassigned charges ²
	Total	Unassigned		
Tennessee	\$1,622.7	\$48.8	15.0	7.3
Alabama	1,398.5	22.7	17.0	3.9
Mississippi	660.8	23.0	16.5	3.8
West South Central:				
Arkansas	774.9	20.1	17.2	3.5
Louisiana	1,319.5	44.4	17.4	7.7
Oklahoma	723.2	81.9	16.9	13.9
Texas	4,181.9	270.8	17.1	46.4
Mountain:				
Montana	159.6	35.7	17.7	6.3
Idaho	140.6	53.6	16.1	8.7
Wyoming	50.2	11.2	15.1	1.7
Colorado	626.0	57.8	17.1	9.9
New Mexico	252.3	17.2	17.1	3.0
Arizona	1,018.4	87.7	16.3	14.2
Utah	256.9	15.9	17.0	2.7
Nevada	452.4	4.8	18.5	0.9
Pacific:				
Washington	769.6	144.1	4.5	6.4
Oregon	553.1	82.6	16.5	13.6
California	7,677.3	377.9	18.2	68.8
Alaska	46.7	2.4	17.6	0.4
Hawaii	219.4	7.6	20.0	1.5

¹Rates reflect covered charges for physician claims processed during the period. National data exclude data for Puerto Rico, the Virgin Islands, the Railroad Retirement Board, and Parenteral and Enteral Claims. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge medical necessity and global fee/rebundling.

²Amounts in millions.

³Massachusetts enacted a Medicare mandatory assignment provision, effective April 1986. The fact that the assignment rates shown here are not 100 percent may be explained by the inclusion in the database of billings by practitioners other than allopathic and osteopathic physicians, which are included in the Medicare statutory definition of "physician".

⁴For fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.

⁵For fiscal year 1993, includes data for all counties in Kansas excluding two counties on the State border.

⁶For fiscal year 1993, includes data for all counties in Maryland excluding two counties on the State border.

⁷For fiscal year 1993, includes data for DC plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia, near the State border.

⁸For fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Health Care Financing Administration, Bureau of Program Operations.

The changing pattern of charge reductions reflects, in part, overall changes in participation and assignment rates. As shown in table E-14, participating physicians accounted for a growing share of total physician charges. During the first participation period (fiscal year 1985), participating physicians (30.4 percent of all physi-

cians) accounted for 36.0 percent of all physician charges. In 1993, the proportion of physicians participating grew to 59.8 percent, and accounted for 85.5 percent of all physician charges. Total covered charges represented by unassigned claims declined from 34.5 percent to 6.0 percent over the same period. The proportion of charges billed by participation and assignment status varies by State; these data are shown in table E-15.

TABLE E-14.—DISTRIBUTION OF ALLOWED CHARGES FOR SERVICES BILLED, BY PARTICIPATION STATUS OF PHYSICIAN AND ASSIGNMENT STATUS OF CLAIM, 1984-1993¹

[In percent]

Time period	Total	Parti- cipants	Nonparticipants	
			Assigned	Unas- signed
Oct. 1984-Sept. 1985	100.0	36.0	29.5	34.5
Oct. 1985-Mar. 1986	100.0	36.3	29.4	34.3
Apr. 1986-Dec. 1986 ²	100.0	39.1	28.0	32.9
Jan. 1987-Mar. 1988 ³	100.0	48.1	25.2	26.7
Apr. 1988-Dec. 1988	100.0	57.9	21.0	21.1
Jan. 1989-Mar. 1990	100.0	62.0	19.0	18.5
Apr. 1990-Dec. 1990	100.0	67.2	16.7	16.1
Jan. 1991-Dec. 1991	100.0	72.3	14.6	13.1
Jan. 1992-Dec. 1992	100.0	78.8	11.6	9.7
Jan. 1993-Dec. 1993	100.0	85.5	8.5	6.0

¹ Rates reflect covered charges for physician claims processed during the period. Data for up to seven carriers missing from various quarters.

² The actual participation period was May through December 1986, and the participation agreements were in effect for that time.

³ The actual participation period is January 1987 through March 1988, and the participation agreements are in effect for that time.

Source: Health Care Financing Administration, Bureau of Program Operations.

TABLE E-15.—DISTRIBUTION OF ALLOWED CHARGES FOR SERVICES BILLED, BY PARTICIPATION STATUS OF PHYSICIAN AND ASSIGNMENT STATUS OF CLAIM, BY STATE, JANUARY–DECEMBER 1993 ¹

Census division/State	Total	Participating physician	Nonparticipating physician	
			Assigned	Unassigned
National	100.0	85.5	8.5	6.0
New England:				
Maine	100.0	92.4	5.8	1.8
New Hampshire	100.0	88.1	6.5	5.3
Vermont	100.0	94.8	4.0	1.2
Massachusetts	100.0	95.9	3.7	0.3
Rhode Island	100.0	98.9	0.9	0.2
Connecticut	100.0	87.9	7.4	4.7
Middle Atlantic:				
New York	100.0	77.7	13.7	8.7
New Jersey	100.0	72.6	14.0	13.4
Pennsylvania	100.0	98.0	1.5	0.5
East North Central:				
Ohio	100.0	94.6	4.4	1.1
Indiana	100.0	89.1	4.8	6.1
Illinois	100.0	82.2	8.6	9.2
Michigan	100.0	95.1	3.0	1.9
Wisconsin	100.0	76.9	11.8	11.3
West North Central:				
Minnesota	100.0	49.5	19.6	30.9
Iowa	100.0	80.8	6.4	12.8
Missouri ²	100.0	67.7	25.3	7.1
North Dakota	100.0	65.8	9.9	24.3
South Dakota	100.0	36.0	16.5	47.5
Nebraska	100.0	79.8	5.8	14.5
Kansas ³	100.0	94.6	2.0	3.4
South Atlantic:				
Delaware	100.0	93.5	3.5	3.0
Maryland ⁴	100.0	87.1	9.9	3.1
District of Columbia ⁵	100.0	90.1	4.4	5.6
Virginia ⁶	100.0	90.9	5.4	3.7
West Virginia	100.0	93.4	5.2	1.4
North Carolina	100.0	87.1	7.1	5.9
South Carolina	100.0	86.6	8.3	5.1
Georgia	100.0	81.6	13.3	5.1
Florida	100.0	89.0	6.8	4.3
East South Central:				
Kentucky	100.0	90.7	5.5	3.7
Tennessee	100.0	91.8	4.9	3.3
Alabama	100.0	94.9	3.3	1.7
Mississippi	100.0	88.6	7.5	4.0
West South Central:				
Arkansas	100.0	93.4	3.6	3.0
Louisiana	100.0	89.4	6.3	4.3
Oklahoma	100.0	74.0	12.8	13.2

TABLE E-15.—DISTRIBUTION OF ALLOWED CHARGES FOR SERVICES BILLED, BY PARTICIPATION STATUS OF PHYSICIAN AND ASSIGNMENT STATUS OF CLAIM, BY STATE, JANUARY–DECEMBER 1993 ¹—Continued

[In percent]

Census division/State	Total	Participating physician	Nonparticipating physician	
			Assigned	Unassigned
Texas	100.0	81.5	11.0	7.5
Mountain:				
Montana	100.0	58.9	16.1	25.0
Idaho	100.0	41.2	16.1	42.7
Wyoming	100.0	61.0	10.7	28.3
Colorado	100.0	76.4	12.1	11.6
New Mexico	100.0	78.2	14.4	7.4
Arizona	100.0	83.7	7.0	9.4
Utah	100.0	83.1	10.9	6.0
Nevada	100.0	96.0	3.1	0.9
Pacific:				
Washington	100.0	50.7	25.2	24.0
Oregon	100.0	73.6	11.1	15.3
California	100.0	86.6	8.1	5.4
Alaska	100.0	81.3	13.1	5.6
Hawaii	100.0	90.6	6.0	3.3

¹ Rates reflect covered charges for physician claims processed during the period.

² For fiscal year 1993, includes data for all counties in Missouri plus two counties on the State border located in Kansas.

³ For fiscal year 1993, includes data for all counties in Kansas excluding two counties on the State border.

⁴ For fiscal year 1993, includes data for all counties in Maryland excluding two counties on the State border.

⁵ For fiscal year 1993, includes data for DC plus two counties in Maryland located on the State border plus a few counties and cities located in Virginia, near the State border.

⁶ For fiscal year 1993, includes data for all counties in Virginia excluding a few counties and cities near the State border.

Source: Health Care Financing Administration, Bureau of Program Operations.

DISTRIBUTION OF PHYSICIAN SERVICES

Tables E-16 to E-24 show the distribution of physicians' services for calendar year 1992. These tables provide data from the first year of the implementation of the Medicare Fee Schedule. As noted earlier, the fee schedule appears to be having its intended effect. The projected pattern of redistribution from the procedurally oriented specialties to the primary care specialties has begun taking place.

The 1992 data are tabulations from the 1992 National Claims History Procedure Summary, which is a summary of all claims filed with the Medicare carriers.

The totals shown will differ from total SMI outlay figures for 1992 shown in the budget for several reasons:

The amounts shown in these tables are allowed amounts, rather than reimbursements—that is, they include both Medicare's and the enrollee's share of approved changes.

The amounts shown are for services rendered during calendar year 1992; budget figures are for payments made during the fiscal year regardless of when the services were rendered.

The amounts shown are only for services reimbursed by carriers under the fee schedule; hence, they do not include Part B payments to hospital outpatient departments or to risk-based prepaid medical plans.

Further, the amounts shown underestimate what they are supposed to represent by a small amount because some claims for services rendered in 1992 had not been processed by carriers at the time the 1992 files were submitted to HCFA, and because some claims recorded had to be eliminated due to recording errors.

Table E-16 illustrates that in 1992, 77.2 percent of allowed amounts under the fee schedule were for physicians' services, and another 3.0 percent were for the services of limited license practitioners—psychologists, podiatrists, optometrists, audiologists, chiropractors, dentists, and physical therapists. About 4.7 percent went to independent laboratories in 1992, while 15.1 percent went to suppliers of medical equipment, prosthetics, and ambulance services.

TABLE E-16.—ALLOWED AMOUNTS FOR CLAIMS, BY TYPE OF PROVIDER, 1992

Type of provider	Allowed amounts (millions)	Percent of total	Percent inpatient
Physicians	\$33,941.0	77.2	39.3
Limited license practitioners ¹	1,307.0	3.0	1.7
Laboratories	2,072.0	4.7	.2
Medical suppliers ²	6,625.0	15.1	.8
All providers ³	43,944.0	100.0	30.6

¹ Includes psychology, podiatry, optometry, audiology, chiropractice, dentistry, and physical therapy.

² Includes suppliers of medical equipment, prosthetics, and ambulance services.

³ Total does not include charges for hospital outpatient department facility fees or for risk-based prepaid medical plans since these are not reimbursed under the CPR system.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, National Claims History Procedure Summary.

Almost 31 percent of all allowed amounts were for hospital inpatient services, and almost 40 percent of allowed amounts for physicians' services were inpatient. The share of physicians' services that are inpatient has dropped in recent years, from nearly 64 percent in 1981.

Table E-17 shows the distribution of spending for physicians' services by specialty. (It excludes limited license practitioners, labs, and suppliers.) In 1992, generalists accounted for 27.8 percent of spending, nonsurgical specialists for 24.1 percent, and surgical specialists for 31.7 percent. Radiologists, anesthesiologists, and pathologists together accounted for 13.6 percent of allowed amounts. Radiation oncologists, osteopathic manipulative therapists, intensivists, and emergency medicine physicians each accounted for less than 1 percent of total allowed amounts for physicians' services.

The major physician specialties treating the Medicare population, in descending order of importance as measured by total allowed amounts, were general internists (14.9 percent of allowed amounts), ophthalmologists (10.9 percent), radiologists (8.6 percent), cardiologists (8.4 percent) and family practitioners (6.0 percent).

The share of services provided on an inpatient basis varied by specialty, generally increasing with specialization. About 33 percent of the services of generalists were inpatient in 1992. The inpatient share for nonsurgical specialists was 46.6 percent and 39.3 percent for surgical specialists.

TABLE E-17.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY MEDICAL SPECIALTY, 1992

Specialty	Allowed amounts (millions)	Percent of total	Percent inpatient
Generalists:			
General practice	\$1,114.0	3.3	18.6
Family practice	2,048.0	6.0	25.6
Internal medicine	5,054.0	14.9	38.6
Pediatrics	28.0	.1	25.6
Clinics	1,186.0	3.5	34.9
All generalists	9,430.0	27.8	32.9
Nonsurgical specialists:			
Allergy/immunology	95.0	.3	10.6
Cardiology	2,860.0	8.4	58.2
Dermatology	682.0	2.0	1.4
Gastroenterology	950.0	2.8	45.2
Neurology	486.0	1.4	48.7
Psychiatry	664.0	2.0	41.2
Physical medicine and rehabilitation	217.0	.6	60.6
Pulmonary disease	639.0	1.9	68.3
Nuclear medicine	62.0	.2	27.1
Geriatric medicine	52.0	.2	34.3
Nephrology	539.0	1.6	52.8
Infectious disease	127.0	.4	74.6
Endocrinology	94.0	.3	37.4
Rheumatology	132.0	.4	16.2
Peripheral vascular disease	22.0	.1	61.8
Hematology/oncology	440.0	1.3	24.3
Medical oncology	117.0	.3	22.1
All nonsurgical specialists	8,176.0	24.1	46.6
Surgical specialists:			
General surgery	1,870.0	5.5	64.9
Otolaryngology	404.0	1.2	17.1
Neurosurgery	287.0	.8	84.3
Gynecology/Obstetrics	261.0	.8	41.7
Ophthalmology	3,689.0	10.9	3.6

TABLE E-17.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY MEDICAL SPECIALTY, 1992—Continued

Specialty	Allowed amounts (millions)	Percent of total	Percent inpatient
Orthopedic surgery	1,611.0	4.7	61.1
Plastic and reconstructive surgery ...	164.0	.5	32.4
Colorectal surgery	69.0	.2	34.0
Thoracic surgery	718.0	2.1	89.3
Urology	1,362.0	4.0	35.9
Hand surgery	21.0	.1	21.4
Vascular surgery	141.0	.4	74.3
Cardiac surgery	164.0	.5	96.4
Surgical oncology	13.0	.....	60.5
All surgical specialists	10,774.0	31.7	39.3
Radiology	2,912.0	8.6	29.9
Radiation oncology	268.0	.8	5.3
Anesthesiology	1,198.0	3.5	71.0
Pathology	519.0	1.5	46.0
Osteopathic manipulative therapy	30.0	.1	15.6
Critical care (Intensivists)	28.0	.1	76.5
Emergency medicine	215.0	.6	6.8
Other Physician specialties	389.0	1.1	49.3
Total—all physicians	33,941.0	100.0	39.3

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, National Claims History Procedure Summary.

Table E-18 shows the distribution of spending for physicians' services by type of service. About 36.8 percent of spending was for medical care (nonsurgical) in 1992. About 35.5 percent of spending was for surgical procedures in total, adding together the amounts for surgeons, assistant surgeons, and anesthesiologists. About 10.6 percent was for diagnostic laboratory tests, which would include not only blood chemistry analysis and urinalysis, but also tests such as EKGs. About 10.3 percent of spending was for radiology, and 4.8 percent was for consultations.

TABLE E-18.—ALLOWED AMOUNTS FOR PHYSICIANS' SERVICES, BY TYPE OF SERVICE, 1992

Type of service	Allowed amounts (millions)	Percent of total	Percent inpatient
Medical care	\$12,503.0	36.8	36.1
Surgery	10,490.0	30.9	49.9
Assistance at surgery	246.0	.7	89.2
Anesthesia	1,319.0	3.9	68.7
Diagnostic laboratory tests	3,597.0	10.6	18.7
Diagnostic radiology	2,775.0	8.2	26.8
Therapeutic radiology	698.0	2.1	5.0
Consultations ¹	1,641.0	4.8	62.0
Other ²	672.0	2.0	1.5
All services	33,941.0	100.0	39.3

¹ Includes first and second opinions for surgery.

² Includes treatment for renal patients, pneumococcal vaccine, and medical supplies, among other things.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, National Claims History Procedure Summary.

Table E-19 lists the top 20 individual services, ranked by total allowed amounts on claims submitted by selected physicians for 1992. The most important exclusion is amounts for the services of anesthesiologists, since there would typically be a charge for anesthesiology for the surgical procedures. The amounts for surgical procedures include claims by both the primary surgeon and any assistant surgeons, but not the amounts for anesthesiologists.

The top 20 services (out of more than 7,000) accounted for 36.9 percent of all spending for all physicians' services in 1992. Cataract extraction with implantation of an intraocular lens was the highest-ranked surgical procedure, accounting by itself for 5.7 percent of total allowed amounts for physicians' services. Other surgical procedures in the top 20 included total knee replacement and heart catheterization and coronary angiography. Most of the remaining services in the top 20 were evaluation and management services (that is, visits and consultations).

Table E-20 presents total allowed amounts for selected groups of generic services, and shows the percent of total allowed amounts for all physicians' services accounted for by each group. As in table E-19, certain physicians' services—most notably for anesthesiologists—are not included in the allowed amounts for each service group. No attempt was made to define and rank all possible service groups, so that there may be other important service groups that do not appear in the table. For example, diagnostic radiology accounts for 8.2 percent of allowed amounts for physicians' services (from table E-18), but radiological services do not appear in table E-20.

TABLE E-19.—THE TOP 20 SERVICES BILLED BY PHYSICIANS UNDER MEDICARE, 1992

Service code and description	Allowed amounts (millions) ¹	Percent of total
Top 20 services:		
99213—Office/outpatient visit, EST	\$2,103	6.2
66984—Remove cataract, insert lens	1,947	5.7
99232—Subsequent hospital care	1,271	3.7
99214—Office/outpatient visit, EST	1,087	3.2
99231—Subsequent hospital care	1,027	3.0
99212—Office/outpatient visit, EST	675	2.0
99233—Subsequent hospital care comprehensive	514	1.5
93307—Echo exam of heart	419	1.2
99223—Initial hospital care	382	1.1
99215—Office/outpatient visit, EST	368	1.1
99254—Initial inpatient consult	357	1.1
66821—After cataract laser surgery	343	1.0
90844—Psychotherapy 45–50 Min	313	.9
99222—Initial hospital care	272	.8
92014—Eye exam & treatment	264	.8
27447—Total knee replacement	262	.8
99238—Hospital discharge day	250	.7
93547—Heart catheter & angiogram	245	.7
99244—Office consultation	224	.7
99255—Initial inpatient consult	212	.6
Total	12,536	36.9

¹ Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, National Claims History Procedure Summary.

The 21 service groups shown in table E-20 accounted for 44.1 percent of all allowed amounts for all physicians' services in 1992. The single most costly group was office visits (accounting for 14.4 percent of total allowed amounts for physicians' services), followed by hospital visits (11.1 percent). Cataract surgery of all types accounted for 5.8 percent of total allowed amounts for physicians' services. It should also be noted that the amount for hemodialysis includes only physician services and does not include the much larger amounts for the facility charges for hemodialysis that were not billed under the fee-for-service reimbursement system.

TABLE E-20.—ALLOWED AMOUNTS FOR SELECTED GROUPS OF PHYSICIANS' SERVICES, 1992

Service group	1991	
	Allowed amounts (millions) ¹	Percent of total
Hospital visits (99221-99238)	\$3,764	11.1
Office visits (99201-99215)	4,896	14.4
Cataract surgery (66830-66985)	1,985	5.8
EKGs (93000-93018, 93015-26)	364	1.1
Transurethral surgery (52601)	159	.5
Coronary artery bypass (33510-33516)	495	1.5
Hip arthroplasty (27130-27132)	144	.4
Cardiac catheterization (93501-93553)	598	1.8
Colonoscopy (45378-45385, 44388-44393, 45355)	485	1.4
Hemodialysis/CAPD (90935-90947)	165	.5
Thromboendarterectomy (35301-35381)	100	.3
Knee arthroplasty (27446, 27447, 29881)	293	.9
Pacemaker implant/removal (33200-33210, 33232)	89	.3
Vein bypass (35501-35587)	71	.2
Emergency room visits (99281-99285)	610	1.8
SNF visits (99301-99313)	455	1.3
Nursing home visits (99321-99333)	36	.1
Home visits (99341-99353)	56	.2
Prostatectomy (55801-55845)	82	.2
EEGs (95816-95827, 95950, 95955)	33	.1
Pacemaker tests (93731-93736)	71	.2
Total	14,951	44.1

¹ Amounts for surgical procedures include fees for primary and assistant surgeons, but not for anesthesiologists.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, National Claims History Procedure Summary.

In recent years, there have been many changes in the delivery of health care services. Some of the more significant changes affecting Medicare services have been in the delivery of surgical services. First, there has been significant growth in the amount of surgical care provided by some specialties. Second, there has been a dramatic shift in the place of surgical care; that is, surgical care is now frequently provided in outpatient settings, whereas previously, most surgical care was provided in inpatient settings.

As shown in table E-21, the most significant shift in site of surgical care between 1980 and 1992 was out of inpatient settings and into other settings. Outpatient hospital settings benefited most from this shift, growing from only 3.3 percent of all surgical charges in 1980 to 25.5 percent in 1992. The proportions of surgery taking place in a physician's office and in other nonhospital settings also grew somewhat. In 1992 the proportion of all surgical care provided in inpatient settings had dropped to 47.9 percent.

TABLE E-21.—CHARGES SUBMITTED TO MEDICARE FOR ALL PHYSICIAN SURGICAL SERVICES, BY PLACE OF SERVICE, 1980, 1990–92

Place of service	Surgical charges ¹		
	Amount in millions	Percent of surgical charges	As percent of total settings charges
1980:			
Total	\$3,828	100.0	31.8
Office	445	11.6	12.2
Outpatient hospital	129	3.3	29.5
Inpatient hospital	3,231	84.4	44.1
Other ²	23	.6	3.7
1990:			
Total	11,048	100.0	33.3
Office	2,004	18.1	16.2
Outpatient hospital ¹	2,867	26.0	54.3
Inpatient hospital	5,563	50.4	40.6
Ambulatory surgical center	488	4.4	51.2
Other ²	127	1.1	14.5
1991:			
Total	11,773	100.0	32.9
Office	2,230	18.9	16.1
Outpatient hospital ¹	2,993	25.4	52.5
Inpatient hospital	5,834	49.6	41.1
Ambulatory surgical center	514	4.4	54.2
Other ²	201	1.7	18.9
1992:			
Total	10,958	100.0	31.3
Office	2,103	19.2	14.8
Outpatient hospital ¹	2,791	25.5	50.3
Inpatient hospital	5,249	47.9	39.2
Ambulatory surgical center	622	5.7	90.3
Other ²	193	1.8	16.6

¹ May include some services rendered in an ambulatory surgical center.

² Includes homes, nursing homes, and other places of service.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, Part B Extract Summary System.

Table E-22 shows the percent of total surgical charges by specialty in 1980 and 1992. In 1980, three specialties (ophthalmology, general surgery, and orthopedic surgery) accounted for nearly half of all Medicare surgical care. These same three specialties accounted for close to the same proportion of total surgical care in 1992, but the shares among these specialties changed. While ophthalmologists accounted for only 13.6 percent in 1980, by 1991 their share had increased to 22.7 percent due primarily to the sub-

stantial growth in cataract surgery during the 1980s. For two specialties, gastroenterology and otology, laryngology and rhinology (or ENT), surgical care represented much larger proportions of their total Medicare practice in 1992 than in 1980. On the other hand, surgical charges for urologists represented much smaller proportions of their total Medicare practice in 1992 than in 1980.

TABLE E-22.—SUBMITTED SURGICAL CHARGES UNDER MEDICARE AS A SHARE OF TOTAL SURGICAL CHARGES AND AS A PERCENT OF TOTAL PRACTICE CHARGES, BY MEDICAL SPECIALTY, 1980 AND 1992

Specialty	Percent distribution of surgical charges		Surgical charges as a percent of total practice charges	
	1980	1992	1980	1992
All physicians	100.0	100.0	31.8	31.3
Ophthalmology	13.6	22.7	62.1	67.5
General surgery	22.1	11.9	71.6	70.0
Orthopedic surgery	13.0	10.6	73.6	71.9
Urology	10.7	6.5	75.6	52.6
Thoracic surgery	8.0	5.4	82.2	81.9
Clinic and other group practice	4.7	2.4	25.8	22.5
Internal medicine	4.2	3.3	6.9	7.1
Cardiovascular disease	2.7	7.3	22.4	28.0
Podiatry	3.0	4.0	53.5	61.4
Gastroenterology	1.7	5.6	45.9	65.2
Dermatology	2.4	4.3	60.9	69.3
Neurological surgery	2.9	2.0	70.2	78.2
Othology, laryngology, rhinology	1.9	.0	49.7	66.0
Plastic surgery	1.3	1.3	88.1	85.8
Other	8.4	12.6	.....	9.9

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, Part B Extract Summary System.

As shown in table E-23, many different medical specialties participated in the shift to outpatient surgery. In 1980, only two specialties (dermatology and podiatry) performed the majority of their surgical services in outpatient settings; in these cases, the care was generally provided in the physician's office. In 1992, seven specialties provided a majority of their surgical care in outpatient settings: ophthalmology, podiatry, gastroenterology, dermatology, ENT, internal medicine, and plastic surgery. Podiatrists and dermatologists continued primarily to work in their offices; internist split their non-inpatient work between office and outpatient settings, while the other specialties provided their surgical services in outpatient hospital and ambulatory surgical facilities. Most surgical specialties, such as general, orthopedic, cardiovascular, neurological and thoracic surgeons, remained closely tied to inpatient hospital settings.

TABLE E-23.—SUBMITTED SURGICAL CHARGES UNDER MEDICARE, BY MEDICAL SPECIALTY AND PLACE OF SERVICE, 1980 AND 1992

[In percent]

Specialty	1980					1992				
	All set- tings	Office	Inpa- tient hos- pital	Out- pa- tient hos- pital	Other ¹	All set- tings	Office	Inpa- tient hos- pital	Out- pa- tient hos- pital ²	Other ¹
All physicians	100.0	11.6	84.4	3.3	0.5	100.0	19.2	47.9	25.5	5.7
General surgery	100.0	4.4	92.6	2.9	.1	100.0	6.0	73.7	18.8	1.0
Cardiovascular disease	100.0	1.7	97.9	.4	(4)	100.0	2.6	86.4	10.3	0.1
Dermatology	100.0	94.6	4.0	.9	.6	100.0	97.5	0.5	1.3	0.4
Gastroenterology	100.0	12.0	75.6	12.3	.1	100.0	9.5	38.9	46.9	4.3
Internal medicine	100.0	17.5	76.6	5.7	.2	100.0	25.4	44.5	28.2	1.5
Neurological surgery	100.0	1.1	98.5	.5	(4)	100.0	1.6	94.8	3.2	0.1
Obstetrics/Gynecology	100.0	.....	.....	.....	.....	100.0	14.3	72.5	12.1	.8
Otology, Laryngology, Rhinology	100.0	12.6	83.7	3.7	(4)	100.0	14.0	4.0	55.2	1.4
Ophthalmology	100.0	7.9	87.1	5.0	.1	100.0	18.8	4.7	53.3	2.5
Orthopedic Surgery	100.0	6.3	90.2	3.4	.1	100.0	7.7	78.0	12.9	1.0
Plastic Surgery	100.0	13.0	67.2	19.7	.1	100.0	22.0	33.8	37.3	5.8
Thoracic surgery	100.0	.8	98.7	.5	(4)	100.0	1.3	95.8	2.6	0.1
Urology	100.0	8.0	90.6	1.4	.1	100.0	23.5	57.5	17.6	1.0
Podiatry	100.0	71.3	13.5	.9	14.3	100.0	70.4	1.6	5.3	1.3
Clinic and other group practice	100.0	10.1	85.3	4.5	.1	100.0	14.1	57.8	25.7	1.9
Other	100.0	.....	.....	.....	.....	100.0	21.0	54.7	22.2	1.5

¹ Includes homes, nursing homes, and other places of service.² May include some services rendered in an ASC.³ Ambulatory surgical center.⁴ Less than .05.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, Part B Extract Summary System.

TABLE E-24.—PERCENT DISTRIBUTION OF ALLOWED SURGICAL CHARGES UNDER MEDICARE, BY MEDICAL SPECIALTY AND PLACE OF SERVICE, 1992

Place of service	Percent
Inpatient hospital:	
General surgery	18.4
Orthopedic surgery	17.2
Thoracic surgery	10.7
Urology	7.9
Cardiovascular disease	13.2
Clinic and other group practice	2.9
Gastroenterology	4.6
Internal medicine	3.0
Ophthalmology	2.2
Neurological surgery	4.1
Other medical and surgical specialties	15.8
Total	100.0
Office:	
Ophthalmology	22.2
Dermatology	21.9
Podiatry	14.7
Urology	8.0
Internal medicine	4.3
General surgery	3.7
Orthopedic surgery	4.3
Gastroenterology	2.8
Family practice	1.4
Clinic and other group practice	1.8
Other medical and surgical specialties	14.9
Total	100.0
Outpatient hospital:	
Ophthalmology	47.6
Gastroenterology	10.4
General surgery	8.8
Orthopedic surgery	5.4
Internal medicine	3.8
Urology	4.5
Clinic and other group practice	2.5
Otology, larynology, rhinology	0.9
Plastic surgery	1.9
Other medical and surgical specialties	14.3
Total	100.0

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, Part B Extract Summary System.

In 1992, ophthalmologists provided most (47.6 percent) of the surgery done in outpatient hospital settings (see table E-24). The predominance of ophthalmologists in this setting is due to cataract surgery. Ophthalmologists also accounted for the largest proportion of office surgical charges, 22.2 percent. However, dermatologists and podiatrists also represented significant percentages of office surgical charges, 21.9 and 14.7 percent respectively. In inpatient settings, the traditional surgical specialties—general surgery, orthopedic surgery, cardiovascular surgery, thoracic surgery and urology accounted for 67.4 percent of all surgical charges.

TABLE E-25.—GEOGRAPHIC PRACTICE COST INDICES, BY MEDICARE CARRIER LOCALITY

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
510	5	Birmingham, AL	0.981	0.913	0.824
510	4	Mobile, AL .....	.964	.911	.824
510	2	North Central Alabama .....	.970	.867	.824
510	1	Northwest Alabama .....	.985	.869	.824
510	6	Rest of Alabama .....	.975	.851	.824
510	3	Southeast Alabama .....	.972	.869	.824
1020	1	Alaska	1.106	1.255	1.042
1030	5	Flagstaff (City), AZ .....	.983	.911	1.255
1030	1	Phoenix, AZ	1.003	1.016	1.255
1030	7	Prescott (City), AZ .....	.983	.911	1.255
1030	99	Rest of Arizona .....	.987	.943	1.255
1030	2	Tucson (City), AZ .....	.987	.989	1.255
1030	8	Yuma (City), AZ .....	.983	.911	1.255
520	13	Arkansas .....	.960	.856	.302
2050	26	Anaheim-Santa Ana, CA	1.046	1.220	1.370
542	14	Bakersfield, CA	1.028	1.050	1.370
542	11	Fresno/Madera, CA	1.006	1.009	1.370
542	13	Kings/Tulare, CA .....	.999	1.001	1.370
2050	18	Los Angeles, CA (1st of 8)	1.060	1.196	1.370
2050	19	Los Angeles, CA (2d of 8)	1.060	1.196	1.370
2050	20	Los Angeles, CA (3d of 8)	1.060	1.196	1.370
2050	21	Los Angeles, CA (4th of 8)	1.060	1.196	1.370
2050	22	Los Angeles, CA (5th of 8)	1.060	1.196	1.370
2050	23	Los Angeles, CA (6th of 8)	1.060	1.196	1.370
2050	24	Los Angeles, CA (7th of 8)	1.060	1.196	1.370
2050	25	Los Angeles, CA (8th of 8)	1.060	1.196	1.370
542	3	Marin/Napa/Solano, CA	1.012	1.198	1.370
542	10	Merced/Surrounding Counties, CA	1.018	1.009	1.370
542	12	Monterey/Santa Cruz, CA	1.023	1.108	1.370
542	1	North Coastal Counties, CA	1.003	1.072	1.370
542	2	Northeast Rural California	1.001	.990	1.370
542	7	Oakland-Berkeley, CA	1.028	1.258	1.370
542	27	Riverside, CA	1.026	1.080	1.370
542	4	Sacramento/Surrounding Counties, CA	1.026	1.088	1.370
542	15	San Bernardino/East Central, CA	1.025	1.077	1.370
2050	28	San Diego/Imperial, CA	1.026	1.090	1.370
542	5	San Francisco, CA	1.038	1.303	1.370
542	6	San Mateo, CA	1.038	1.303	1.370

TABLE E-25.—GEOGRAPHIC PRACTICE COST INDICES, BY MEDICARE CARRIER
LOCALITY—Continued

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
2050	16	Santa Barbara, CA	1.012	1.073	1.370
542	9	Santa Clara, CA	1.048	1.286	1.370
542	8	Stockton/Surrounding Counties, CA ..	1.019	1.027	1.370
2050	17	Ventura, CA	1.034	1.132	1.370
550	1	Colorado .....	.999	.988	.683
10230	4	Eastern Connecticut .....	.999	1.053	1.036
10230	1	Northwest and North Central Connecticut	1.002	1.071	1.025
10230	3	South Central Connecticut	1.018	1.103	1.188
10230	2	Southwest Connecticut	1.053	1.139	1.231
570	1	Delaware	1.026	1.018	.664
580	1	D.C.+MD/VA suburbs	1.059	1.168	.947
590	3	Fort Lauderdale, FL .....	.993	.981	1.376
590	4	Miami, FL	1.034	1.025	1.641
590	2	North/North central Florida cities .....	.975	.932	1.108
590	1	Rest of Florida .....	.966	.871	1.108
1040	1	Atlanta, GA .....	.975	1.022	.752
1040	4	Rest of Georgia .....	.956	.841	.752
1040	2	Small Georgia cities 02 .....	.962	.895	.752
1040	3	Small Georgia cities 03 .....	.961	.869	.752
1120	1	Hawaii	1.003	1.094	1.025
5130	12	North Idaho .....	.965	.917	.889
5130	11	South Idaho .....	.967	.936	.889
621	10	Champaign-Urbana, IL .....	.965	.920	1.137
621	16	Chicago, IL	1.044	1.114	1.773
621	3	De Kalb, IL .....	.978	.925	1.137
621	11	Decatur, IL .....	.981	.927	1.137
621	12	East St. Louis, IL .....	.989	.958	1.579
621	6	Kankakee, IL .....	.972	.925	1.137
621	8	Normal, IL .....	.997	.968	1.137
621	1	Northwest, IL .....	.974	.896	1.137
621	5	Peoria, IL	1.009	1.031	1.137
621	7	Quincy, IL .....	.974	.896	1.137
621	4	Rock Island, IL .....	.995	.958	1.137
621	2	Rockford, IL	1.010	1.018	1.137
621	13	Southeast Illinois .....	.974	.896	1.137
621	14	Southern Illinois .....	.974	.896	1.137
621	9	Springfield, IL .....	.996	.966	1.137
621	15	Suburban Chicago, IL	1.020	1.097	1.137
630	1	Metropolitan Indiana .....	.998	.963	.547
630	3	Rest of Indiana .....	.979	.896	.516
630	2	Urban Indiana .....	.980	.905	.516
640	5	Des Moines (Polk/Warren), IA .....	.997	.966	.666
640	3	North central Iowa .....	.971	.916	.666
640	2	Northeast Iowa .....	.972	.918	.666
640	6	Northwest Iowa .....	.969	.890	.666
640	4	South central Iowa (excludes Des Moines).	.962	.881	.666
640	1	Southeast Iowa (includes Iowa City)	.976	.933	.666

TABLE E-25.—GEOGRAPHIC PRACTICE COST INDICES, BY MEDICARE CARRIER
LOCALITY—Continued

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
640	7	Southwest Iowa .....	.968	.900	.666
740	5	Kansas City, KS .....	.978	.964	1.134
650	1	Rest of Kansas .....	.953	.893	1.134
740	4	Suburban Kansas City, KS .....	.978	.964	1.134
660	1	Lexington and Louisville, KY .....	.984	.917	.667
660	3	Rest of Kentucky .....	.974	.875	.667
660	2	Small cities (city limits) KY .....	.976	.898	.667
528	7	Alexandria, LA .....	.985	.889	.808
528	3	Baton Rouge, LA .....	.991	.966	.808
528	6	Lafayette, LA .....	.982	.928	.808
528	4	Lake Charles, LA .....	.975	.907	.808
528	5	Monroe, LA .....	.979	.880	.808
528	1	New Orleans, LA .....	.994	1.003	1.185
528	50	Rest of Louisiana .....	.972	.880	.824
528	2	Shreveport, LA	1.003	.940	.808
21200	2	Central Maine .....	.942	.903	.716
21200	1	Northern Maine .....	.947	.912	.716
21200	3	Southern Maine .....	.956	.980	.716
690	1	Baltimore/Surrounding Counties, MD	1.027	1.040	.927
690	3	South+Eastern Shore, MD	1.011	1.010	.820
690	2	Western Maryland	1.006	1.013	.843
700	2	Massachusetts suburbs/rural (cities)	.997	1.072	.855
700	1	Massachusetts Urban	1.002	1.131	.855
710	1	Detroit, MI	1.059	1.091	1.736
710	2	Michigan, not Detroit	1.010	.971	1.196
720	00	Minnesota (Blue Shield) .....	.999	.971	.748
10240	00	Minnesota (Travelers) .....	.999	.971	.748
10250	1	Rest of Mississippi .....	.960	.838	.650
10250	2	Urban Mississippi (city limits) .....	.966	.902	.650
740	3	Kansas City (Jackson County), MO ...	.978	.964	1.179
740	2	North Kansas City (Clay/Platte), MO .	.978	.964	1.179
11260	3	Rest of Missouri .....	.950	.847	1.179
740	6	Rural Northwest counties, Missouri ..	.953	.866	1.179
11260	2	Small Eastern Cities, MO .....	.954	.838	1.179
740	1	St. Joseph, MO .....	.950	.867	1.179
11260	1	St. Louis/Large Eastern Cities, MO ...	.988	.964	1.352
751	1	Montana .....	.967	.926	.718
655	00	Nebraska .....	.960	.883	.435
1290	3	Elko and Ely (Cities), NV .....	.984	1.026	1.144
1290	1	Las Vegas, et al (cities), NV	1.036	1.082	1.144
1290	2	Reno, et al (cities), NV	1.008	1.141	1.144
1290	99	Rest of Nevada	1.020	1.079	1.144
780	40	New Hampshire .....	.962	1.011	.602
860	2	Middle New Jersey	1.034	1.070	1.153
860	1	Northern New Jersey	1.040	1.131	1.153
860	3	Southern New Jersey	1.016	1.030	1.153
1360	5	New Mexico .....	.981	.925	.767
801	1	Buffalo/Surrounding Counties, NY	1.006	.942	.963
803	1	Manhattan, NY	1.059	1.255	1.647

TABLE E-25.—GEOGRAPHIC PRACTICE COST INDICES, BY MEDICARE CARRIER LOCALITY—Continued

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
801	3	North central cities, New York .....	.997	.952	.963
803	2	New York City suburbs/Long Island, NY	1.060	1.229	1.929
803	3	Poughkpsie/N. New York City sub-urbs	1.004	1.018	1.325
14330	4	Queens, NY	1.059	1.255	1.861
801	2	Rochester/Surrounding Counties, NY	1.021	1.017	.963
801	4	Rest of New York .....	.988	.935	.963
5535	00	North Carolina .....	.968	.902	.378
820	1	North Dakota .....	.965	.895	.688
16360	00	Ohio .....	.993	.951	.920
1370	00	Oklahoma .....	.969	.911	.516
1380	2	Eugene, et al (cities), OR .....	.968	1.008	.951
1380	1	Portland, et al (cities), OR .....	.993	1.033	.951
1380	99	Rest of Oregon .....	.979	.997	.951
1380	3	Salem, et al (cities), OR .....	.974	.990	.951
1380	12	Southwest Oregon cities (city limits) .....	.974	.988	.951
865	2	Large Pennsylvania cities	1.008	1.001	1.440
865	1	Philly/Pitt Medium Schools/Hospitals	1.014	1.014	1.552
865	4	Rest of Pennsylvania .....	.975	.929	.986
865	3	Small Pennsylvania cities .....	.984	.945	.986
973	20	Puerto Rico .....	.882	.763	.466
870	1	Rhode Island	1.009	.998	.734
880	1	South Carolina .....	.971	.874	.448
820	2	South Dakota .....	.951	.857	.688
5440	35	Tennessee .....	.969	.896	.407
900	29	Abilene, TX .....	.971	.888	.504
900	26	Amarillo, TX .....	.972	.900	.504
900	31	Austin, TX .....	.969	.968	.504
900	20	Beaumont, TX .....	.998	.955	.504
900	9	Brazoria, TX	1.025	.955	.504
900	10	Brownsville, TX .....	.980	.888	.504
900	24	Corpus Christi, TX .....	.976	.944	.504
900	11	Dallas, TX .....	.996	.971	.504
900	12	Denton, TX .....	.996	.971	.504
900	14	El Paso, TX .....	.995	.894	.504
900	28	Fort Worth, TX .....	.973	.936	.504
900	15	Galveston, TX .....	.982	.968	.504
900	16	Grayson, TX .....	.964	.903	.504
900	18	Houston, TX	1.014	.982	.656
900	33	Laredo, TX .....	.968	.856	.504
900	17	Longview, TX .....	.968	.929	.504
900	21	Lubbock, TX .....	.950	.881	.504
900	19	Mc Allen, TX .....	.945	.873	.504
900	23	Midland, TX	1.023	.998	.504
900	2	Northeast rural Texas .....	.968	.883	.504
900	13	Odessa, TX	1.008	.971	.504
900	25	Orange, TX .....	.998	.955	.504
900	30	San Angelo, TX .....	.954	.902	.504

TABLE E-25.—GEOGRAPHIC PRACTICE COST INDICES, BY MEDICARE CARRIER LOCALITY—Continued

Carrier number	Locality number	Locality name	Work	Practice expense	Mal-practice
900	7	San Antonio, TX .....	.973	.929	.504
900	3	Southeast rural Texas .....	.973	.895	.504
900	6	Temple, TX .....	.969	.886	.504
900	8	Texarkana, TX .....	.953	.883	.504
900	27	Tyler, TX .....	.984	.931	.504
900	32	Victoria, TX .....	.976	.973	.504
900	22	Waco, TX .....	.981	.871	.504
900	4	Western rural Texas .....	.961	.852	.504
900	34	Wichita Falls, TX .....	.969	.896	.504
910	9	Utah .....	.993	.952	.739
780	50	Vermont .....	.942	.941	.533
10490	1	Richmond+Charlottesville, VA .....	.975	.953	.462
10490	4	Rest of Virginia .....	.967	.888	.522
10490	3	Small town/Industrial Virginia .....	.971	.892	.531
10490	2	Tidewater+North Virginia Counties ...	.989	.994	.703
973	50	Virgin Islands	1.000	1.000	1.000
932	4	East central+Northeast Washington (excludes Spokane).	.991	.979	1.064
932	2	Seattle (King County), WA	1.019	1.049	1.064
932	3	Spokane+Richland (cities), WA .....	.996	.995	1.064
932	1	West+Southeast Washington (excludes Seattle).	1.008	.992	1.064
16510	16	Charleston, WV .....	.987	.962	.688
16510	18	Eastern Valley, WV .....	.962	.881	.688
16510	19	Ohio River Valley, WV .....	.962	.881	.688
16510	20	Southern Valley, WV .....	.960	.876	.688
16510	17	Wheeling, WV .....	.975	.900	.688
951	13	Central Wisconsin .....	.960	.888	.762
951	40	Green Bay, WI (Northeast) .....	.979	.913	.762
951	54	Janesville, WI (South-Central) .....	.970	.905	.762
951	19	La Crosse, WI (West-Central) .....	.976	.919	.762
951	15	Madison, WI (Dane County) .....	.977	.979	.762
951	46	Milwaukee suburbs, WI (SE)	1.010	1.008	.762
951	4	Milwaukee, WI	1.008	1.009	.762
951	12	Northwest Wisconsin .....	.966	.898	.762
951	60	Oshkosh, WI (East-Central) .....	.974	.911	.762
951	14	Southwest Wisconsin .....	.960	.888	.762
951	36	Wausau, WI (North-Central) .....	.971	.898	.762
825	21	Wyoming .....	.988	.938	.641

Note: Work GPCI is the $\frac{1}{4}$ work GPCI required by Pub. L. 101-239.

Source: Federal Register, Vol. 58, No. 230, December 2, 1993; 63848-63851.

APPENDIX F. DATA ON EMPLOYMENT, EARNINGS, AND UNEMPLOYMENT

The following tables and charts provide additional data on unemployment and the unemployment compensation program.

TABLE F-1.—CIVILIAN UNEMPLOYMENT RATE AND INSURED UNEMPLOYMENT RATE

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Avg.
Civilian Unemployment Rate—Total (Seasonally Adjusted)													
1970	3.9	4.2	4.4	4.6	4.8	4.9	5.0	5.1	5.4	5.5	5.9	6.1	4.9
1971	5.9	5.9	6.0	5.9	5.9	5.9	6.0	6.1	6.0	5.8	6.0	6.0	5.9
1972	5.8	5.7	5.8	5.7	5.7	5.7	5.6	5.6	5.5	5.6	5.3	5.2	5.6
1973	4.9	5.0	4.9	5.0	4.9	4.9	4.8	4.8	4.8	4.6	4.8	4.9	4.9
1974	5.1	5.2	5.1	5.1	5.1	5.4	5.5	5.5	5.9	6.0	6.6	7.2	5.6
1975	8.1	8.1	8.6	8.8	9.0	8.8	8.6	8.4	8.4	8.4	8.3	8.2	8.5
1976	7.9	7.7	7.6	7.7	7.4	7.6	7.8	7.8	7.6	7.7	7.8	7.8	7.7
1977	7.5	7.6	7.4	7.2	7.0	7.2	6.9	6.9	7.0	6.8	6.8	6.4	7.1
1978	6.4	6.3	6.3	6.1	6.0	5.9	6.2	5.9	6.0	5.8	5.9	6.0	6.1
1979	5.9	5.9	5.8	5.8	5.6	5.7	5.7	6.0	5.9	6.0	5.9	6.0	5.8
1980	6.3	6.3	6.3	6.9	7.5	7.6	7.8	7.7	7.5	7.5	7.5	7.2	7.1
1981	7.5	7.4	7.4	7.2	7.5	7.5	7.2	7.4	7.6	7.9	8.3	8.5	7.6
1982	8.6	8.9	9.0	9.3	9.4	9.6	9.8	9.8	10.1	10.4	10.7	10.7	9.7
1983	10.4	10.4	10.3	10.2	10.2	10.1	9.4	9.4	9.2	8.8	8.4	8.2	9.6
1984	8.0	7.8	7.8	7.8	7.5	7.2	7.5	7.5	7.4	7.3	7.1	7.2	7.5
1985	7.4	7.3	7.2	7.3	7.2	7.3	7.3	7.1	7.1	7.1	7.0	7.0	7.2
1986	6.8	7.2	7.2	7.1	7.2	7.1	7.0	6.8	7.0	6.9	6.9	6.7	7.0
1987	6.7	6.6	6.5	6.3	6.3	6.1	6.0	6.0	5.9	6.0	5.9	5.8	6.2
1988	5.8	5.7	5.6	5.4	5.6	5.3	5.4	5.6	5.4	5.3	5.4	5.3	5.5
1989	5.4	5.2	5.1	5.2	5.2	5.4	5.2	5.2	5.3	5.3	5.3	5.3	5.3
1990	5.3	5.3	5.3	5.4	5.3	5.3	5.5	5.6	5.7	5.7	5.9	6.1	5.5
1991	6.2	6.5	6.7	6.6	6.8	6.9	6.8	6.8	6.8	6.9	6.9	7.1	6.7
1992	7.1	7.3	7.3	7.2	7.5	7.8	7.7	7.6	7.5	7.4	7.3	7.3	7.4
1993	7.1	7.0	7.0	7.0	6.9	7.0	6.8	6.7	6.7	6.8	6.5	6.4	6.8

TABLE F-1.—CIVILIAN UNEMPLOYMENT RATE AND INSURED UNEMPLOYMENT RATE—Continued

Year	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Avg.
Insured Unemployment Rate Under State Programs (Seasonally Adjusted)													
1970	2.5	2.7	2.8	3.2	3.5	3.6	3.6	3.7	4.0	4.4	4.4	4.0	3.4
1971	3.9	3.9	4.0	4.1	4.1	4.1	3.9	4.2	4.3	4.2	4.1	4.0	4.1
1972	3.7	3.7	3.6	3.6	3.6	3.5	3.7	3.4	3.4	3.2	3.2	3.2	3.5
1973	2.9	2.8	2.8	2.6	2.7	2.7	2.6	2.8	2.7	2.7	2.7	2.9	2.7
1974	3.1	3.2	3.3	3.2	3.2	3.3	3.3	3.4	3.5	3.7	4.4	5.0	3.5
1975	5.6	5.8	6.4	6.7	6.9	6.8	6.1	5.9	5.8	5.6	5.3	4.9	6.0
1976	4.6	4.3	4.3	4.4	4.5	4.5	4.6	4.6	4.7	4.7	4.7	4.4	4.6
1977	4.3	4.2	4.1	4.0	3.9	3.9	3.8	3.8	3.8	3.8	3.8	3.7	3.9
1978	3.5	3.7	3.6	3.3	3.2	3.2	3.3	3.4	3.2	3.1	2.9	3.2	3.3
1979	3.1	3.2	3.1	3.0	2.8	2.8	2.8	3.0	2.9	3.0	3.1	3.2	2.9
1980	3.3	3.3	3.4	3.7	4.2	4.4	4.4	4.3	4.2	4.0	3.8	3.6	3.9
1981	3.5	3.5	3.4	3.3	3.3	3.3	3.3	3.3	3.4	3.6	3.9	4.0	3.5
1982	4.2	4.0	4.3	4.6	4.5	4.7	4.7	4.7	5.0	5.2	5.3	4.8	4.6
1983	4.5	4.7	4.5	4.4	4.2	3.9	3.7	3.5	3.4	3.3	3.3	3.2	3.9
1984	2.9	2.8	2.9	2.8	2.8	2.7	2.7	2.7	2.7	2.8	2.7	3.0	2.8
1985	2.8	3.0	3.0	2.9	2.8	2.8	2.8	2.8	2.8	2.6	2.8	2.9	2.8
1986	2.7	2.8	2.9	2.8	2.8	2.9	2.8	2.9	2.8	2.8	2.8	2.7	2.8
1987	2.6	2.6	2.6	2.5	2.4	2.4	2.4	2.3	2.2	2.1	2.1	2.2	2.4
1988	2.3	2.3	2.2	2.1	2.1	2.1	2.1	2.1	2.0	2.0	2.0	2.0	2.1
1989	2.1	2.1	2.1	2.1	2.0	2.1	2.2	2.1	2.2	2.2	2.2	2.3	2.1
1990	2.3	2.3	2.3	2.3	2.3	2.3	2.4	2.4	2.4	2.6	2.8	2.8	2.4
1991	3.0	3.1	3.3	3.3	3.2	3.2	3.1	3.1	3.1	3.0	3.1	3.1	3.1
1992	3.2	3.1	3.1	3.2	3.1	3.1	3.1	3.1	3.1	3.0	2.8	2.6	3.0
1993	2.7	2.5	2.5	2.6	2.6	2.7	2.7	2.6	2.7	2.7	2.6	2.6	2.6

Source: U.S. Department of Labor, Bureau of Labor Statistics. Washington, D.C. 1994.

TABLE F-2.—STATE INSURED UNEMPLOYMENT RATES UNDER THE UNEMPLOYMENT COMPENSATION PROGRAM

[Calendar year]

	1985	1986	1987	1988	1989	1990	1991	1992	1993, by quarter			
									I	II	III	IV
Alabama	3.3	3.2	2.8	2.2	2.5	2.7	2.8	2.5	2.4	2.0	2.1	2.0
Alaska	7.1	8.0	6.6	5.6	6.3	6.2	6.2	6.3	6.9	5.5	4.0	5.6
Arizona	1.8	2.0	2.0	1.5	1.9	2.3	2.3	2.4	2.1	2.2	2.2	1.9
Arkansas	3.7	3.6	3.4	3.2	3.3	3.6	3.6	3.5	3.8	2.9	2.5	2.8
California	3.6	3.5	3.0	2.7	2.9	4.1	4.1	4.4	4.5	3.9	3.6	3.8
Colorado	2.3	2.5	2.4	2.0	2.2	1.8	1.8	1.8	2.0	1.6	1.3	1.5
Connecticut	1.8	1.6	1.4	1.3	1.3	3.9	3.9	3.8	3.8	3.5	3.4	3.0
Delaware	1.6	2.0	1.2	1.4	1.3	2.3	2.3	2.4	2.5	1.9	1.9	1.9
District of Columbia	2.1	2.1	2.0	1.8	1.9	2.6	2.6	2.5	2.4	2.2	2.4	2.2
Florida	1.4	1.6	1.2	1.1	1.1	2.3	2.3	2.4	1.9	2.2	2.9	2.3
Georgia	1.8	1.8	1.6	1.4	1.5	2.3	2.3	2.0	1.9	1.5	1.5	1.4
Hawaii	2.5	2.1	1.7	1.5	1.6	1.6	1.6	2.3	2.7	2.5	2.4	2.4
Idaho	4.5	4.8	4.2	3.6	3.9	3.0	3.8	3.7	5.1	3.3	2.4	2.6
Illinois	3.2	2.9	2.6	2.2	2.5	3.1	3.1	3.1	3.4	2.8	2.5	2.3
Indiana	2.3	2.1	1.7	1.4	1.6	1.9	1.9	1.7	1.8	1.3	1.2	1.2
Iowa	3.0	2.9	2.1	1.7	2.0	2.1	2.0	2.0	2.7	1.7	1.5	1.6
Kansas	2.4	2.7	2.4	2.1	2.2	2.2	2.2	2.2	2.3	1.8	1.7	1.8
Kentucky	3.3	3.2	2.4	2.3	2.4	2.9	3.0	2.4	2.7	2.0	1.8	1.8
Louisiana	4.4	5.3	4.1	3.0	3.7	2.3	2.4	2.6	2.5	2.1	2.0	1.9
Maine	3.5	2.9	2.3	1.9	2.1	5.0	5.0	3.9	4.0	3.0	2.1	2.5
Maryland	2.2	2.1	1.7	1.5	1.6	3.1	3.2	3.1	3.2	2.6	2.3	2.2
Massachusetts	2.4	2.5	1.8	2.0	1.9	4.3	4.4	3.6	3.6	3.0	2.6	2.5

TABLE F-2.—STATE INSURED UNEMPLOYMENT RATES UNDER THE UNEMPLOYMENT COMPENSATION PROGRAM—Continued

[Calendar year]

	1985	1986	1987	1988	1989	1990	1991	1992	1993, by quarter			
									I	II	III	IV
Michigan	3.2	3.4	3.5	3.3	3.4	4.0	4.0	3.5	3.6	2.7	2.7	2.4
Minnesota	2.6	2.5	2.1	2.0	2.0	2.4	2.3	2.2	2.8	1.8	1.4	1.6
Mississippi	3.7	4.0	3.2	2.7	3.0	3.2	3.2	3.0	2.8	2.2	2.1	1.9
Missouri	2.6	2.6	2.4	2.2	2.3	3.0	3.0	2.8	3.1	2.2	2.2	1.9
Montana	3.9	3.9	3.4	3.0	3.2	3.2	3.2	3.1	4.6	3.0	2.3	2.9
Nebraska	2.3	2.1	1.8	1.4	1.6	1.3	1.3	1.3	1.8	1.1	0.9	0.9
Nevada	2.8	2.8	2.4	2.0	2.2	3.4	3.4	3.2	3.4	2.9	2.5	2.6
New Hampshire	1.0	0.8	0.6	0.6	0.6	3.0	3.0	2.3	2.1	1.1	1.3	1.5
New Jersey	2.9	2.6	2.4	2.1	2.1	3.9	3.9	3.9	3.9	3.3	3.1	2.9
New Mexico	2.8	3.4	2.9	2.4	2.7	2.4	2.4	2.5	2.6	2.3	1.9	1.8
New York	2.8	2.5	2.2	2.1	2.2	3.7	3.6	3.6	3.5	2.9	2.8	2.8
North Carolina	2.3	1.9	1.6	1.4	1.5	2.6	2.6	2.0	1.7	1.3	1.2	1.3
North Dakota	3.1	2.9	2.6	2.3	2.5	2.0	1.9	1.9	2.8	1.5	1.1	1.3
Ohio	3.0	2.8	2.4	2.1	2.3	2.8	2.8	2.7	2.7	2.0	1.8	1.8
Oklahoma	2.4	3.3	2.3	1.8	2.1	1.8	1.8	2.0	1.8	1.6	1.5	1.4
Oregon	4.6	4.9	3.5	3.1	3.4	4.2	4.2	4.2	4.6	3.8	3.2	3.6
Pennsylvania	4.0	3.6	2.9	2.6	2.8	4.0	4.0	4.0	4.1	3.4	3.0	3.1
Puerto Rico	7.1	5.7	4.9	4.2	4.6	5.9	5.8	6.3	6.4	6.5	7.1	6.6
Rhode Island	3.6	3.1	2.7	2.7	2.7	5.4	5.4	4.9	4.9	3.9	3.6	3.7
South Carolina	2.9	2.1	1.7	1.6	1.7	2.8	2.8	2.6	2.5	1.9	1.9	2.0
South Dakota	1.6	1.4	1.3	1.2	1.2	0.9	0.9	0.9	1.5	0.8	0.6	0.6

Tennessee	2.7	2.4	2.1	2.1	2.1	3.0	3.0	2.5	2.6	1.8	1.9	1.8
Texas	1.6	2.5	2.2	1.8	2.1	2.0	2.0	2.2	2.2	1.9	1.9	1.9
Utah	2.4	2.5	2.2	1.7	2.0	1.6	1.6	1.6	2.0	1.4	1.1	1.0
Vermont	3.1	2.5	2.0	1.8	1.9	4.3	4.4	4.0	4.3	3.6	2.6	2.9
Virginia	2.7	3.2	1.1	1.2	1.2	1.3	2.2	1.6	1.5	1.2	1.0	1.0
Virgin Islands	1.2	1.0	0.9	0.9	0.9	1.7	1.9	1.8	1.4	1.4	1.8	3.0
Washington	4.4	4.1	3.7	3.6	3.6	4.0	4.0	4.0	4.7	3.7	3.4	3.9
West Virginia	4.6	4.2	3.6	3.1	3.4	4.0	3.9	3.6	3.8	3.1	3.0	3.0
Wisconsin	3.5	3.0	2.7	2.2	2.5	3.0	3.0	2.8	3.5	2.4	1.8	1.9
Wyoming	2.4	3.9	3.2	2.3	2.9	2.1	2.0	2.3	2.9	1.9	1.2	1.6
United States	2.8	2.8	2.4	2.1	2.1	2.4	3.1	3.1	3.2	2.6	2.4	2.4

Prepared by DOU/ETAUIS, Division of Actuarial Services.

TABLE F-3.—SELECTED UNEMPLOYMENT RATES

Unemployment rate (percent of civilian labor force in group, seasonally adjusted)												
Period	By sex and age				By race			By selected groups				
	Total (all ci- vilian work- ers)	Men 20 years and over		Women 20 years and over	Both sexes 16-19 years		Black and other ¹	White	Black	Experi- enced wage and salary work- ers		
		Men 20 years and over	Women 20 years and over	Both sexes 16-19 years	Black and other ¹							
1976	7.7	5.9	7.4	19.0	7.0	14.0	13.1	7.3	4.2	10.1	7.3	10.1
1977	7.1	5.2	7.0	17.8	6.2	14.0	13.1	6.6	3.6	9.4	6.6	9.9
1978	6.1	4.3	6.0	16.4	5.2	12.8	11.9	5.6	2.8	8.5	5.6	9.0
1979	5.8	4.2	5.7	16.1	5.1	12.3	11.3	5.5	2.8	8.3	5.3	8.8
1980	7.1	5.9	6.4	17.8	6.3	14.3	13.1	6.9	4.2	9.2	6.9	8.8
1981	7.6	6.3	6.8	19.6	6.7	15.6	14.2	7.3	4.3	10.4	7.3	9.4
1982	9.7	8.8	8.3	23.2	8.6	18.9	17.3	9.3	6.5	11.7	9.6	10.5
1983	9.6	8.9	8.1	22.4	8.4	19.5	17.8	9.2	6.5	12.2	9.5	10.4
1984	7.5	6.6	6.8	18.9	6.5	15.9	14.4	7.1	4.6	10.3	7.2	9.3
1985	7.2	6.2	6.6	18.6	6.2	15.1	13.7	6.8	4.3	10.4	6.8	9.3
1986	7.0	6.1	6.2	18.3	6.0	14.5	13.1	6.6	4.4	9.8	6.6	9.1
1987	6.2	5.4	5.4	16.9	5.3	13.0	11.6	5.8	3.9	9.2	5.8	8.4
1988	5.5	4.8	4.9	15.3	4.7	11.7	10.4	5.2	3.3	8.1	5.2	7.6
1989	5.3	4.5	4.7	15.0	4.5	11.4	10.0	5.0	3.0	8.1	5.1	6.2
1990	5.5	4.9	4.8	15.5	4.7	11.3	10.1	5.3	3.4	8.2	5.2	7.4
1991	6.7	6.3	5.7	18.6	6.0	12.4	11.1	6.5	4.4	9.1	6.5	8.3
1992	7.4	7.0	6.3	20.0	6.5	14.1	12.7	7.1	5.0	9.9	7.1	9.2
1993	6.8	6.4	5.9	19.0	6.0	12.9	11.7	6.5	4.4	9.5	6.5	8.8

¹ Category includes: American Samoans, Native Americans, Asians, and Black Hispanics.

Source: Department of Labor, Bureau of Labor Statistics, and Economic Report of the President, Feb. 1994.

TABLE F-4.—SELECTED MEASURES OF UNEMPLOYMENT

Period	Unemployment (thousands)	Percent distribution of unemployment by duration ¹				Percent distribution of unemployment by reason ¹			
		Less than 5 weeks	5-14 weeks	15-26 weeks	27 weeks and over	Job losers	Job leavers	Reentrants	New entrants
1977	6,991	41.8	30.5	13.1	14.7	45.3	13.0	28.1	13.6
1978	6,202	46.2	31.0	12.4	10.4	41.7	14.1	29.9	14.3
1979	6,137	48.1	31.7	11.5	8.7	42.9	14.3	29.4	13.3
1980	7,637	43.1	32.3	13.8	10.7	51.7	11.7	25.2	11.4
1981	8,273	41.7	30.7	13.6	14.0	51.6	11.2	25.4	11.9
1982	10,678	36.4	31.0	16.0	16.6	58.7	7.9	22.3	11.1
1983	10,717	33.3	27.4	15.4	23.9	58.4	7.7	22.5	11.3
1984	8,539	39.2	28.7	12.9	19.1	51.8	9.6	25.6	13.0
1985	8,312	42.1	30.2	12.3	15.4	49.8	10.6	27.1	12.5
1986	8,237	41.0	32.0	12.4	14.5	47.9	13.0	25.7	13.4
1987	7,425	43.7	29.6	12.7	14.0	48.0	13.0	26.6	12.4
1988	6,701	46.0	30.0	12.0	12.1	46.1	14.7	27.0	12.2
1989	6,528	48.6	30.3	11.2	9.9	45.7	15.7	28.2	10.4
1990	6,874	46.1	32.0	11.8	10.1	48.3	14.8	27.4	9.5
1991	8,426	40.1	32.3	14.5	13.0	54.7	11.6	24.8	8.9
1992	9,384	34.8	29.4	15.2	20.6	56.4	10.4	23.7	9.5
1993	8,734	36.2	28.9	14.6	20.4	54.6	10.8	24.6	10.0

¹ Detail may not add to 100 percent because of rounding.

Source: Economic Report of the President, Feb. 1994.

TABLE F-5.—STATE UNEMPLOYMENT COMPENSATION PROGRAM EXHAUSTIONS—REGULAR BENEFITS

[In thousands]

	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
January	152	147	229	332	261	211	184	215	309	258	421	269	238	290	230	176	168	203	265	359	291
February	127	129	230	295	251	184	160	201	275	267	394	245	207	208	220	170	150	169	228	303	264
March	143	146	278	326	290	201	193	220	291	341	470	251	228	231	245	198	176	191	261	343	303
April	138	167	369	305	265	192	185	259	289	362	431	245	253	256	244	183	166	197	306	364	288
May	141	178	406	273	242	193	195	251	246	338	398	243	235	233	206	174	174	208	314	324	248
June	119	159	438	282	254	176	162	246	244	378	383	198	194	214	204	172	162	184	277	333	268
July	119	190	487	263	215	151	169	298	247	360	336	213	235	245	212	161	161	208	350	356	268
August	124	174	413	254	234	158	166	256	215	365	341	212	205	212	179	169	173	202	316	311	267
September	100	145	370	239	198	138	140	254	207	351	264	163	182	210	170	142	148	169	276	294	251
October	111	155	350	212	183	133	161	292	200	347	244	197	208	223	160	138	152	198	303	276	235
November	110	152	291	231	192	144	159	259	201	384	249	183	180	183	183	148	156	190	260	255	243
December	112	186	336	251	192	149	162	319	265	424	248	188	214	241	184	148	154	205	314	304	260
Total	1,495	1,926	4,195	3,262	2,776	2,030	2,037	3,072	2,989	4,175	4,180	2,607	2,579	2,746	2,408	1,979	1,940	2,324	3,472	3,821	3,186

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE F-6.—STATE UNEMPLOYMENT COMPENSATION PROGRAM EXHAUSTIONS—EXTENDED BENEFITS

[In thousands]

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
January	52	366	177	126	11	24	169	9	91	7	4	5	9	0	(1)	(1)	2	(1)	(1)
February	50	215	166	66	10	15	128	14	95	6	4	6	0	(1)	(1)	(1)	(1)	(1)	(1)
March	100	244	187	50	13	18	134	38	128	7	(1)	5	5	(1)	(1)	2	(1)	1	(1)
April	161	253	177	45	15	28	117	114	153	6	7	5	1	1	(1)	3	3	1	(1)
May	207	190	159	49	31	74	95	134	156	12	9	4	2	1	1	(1)	6	5	(1)
June	228	197	170	49	19	66	90	193	120	3	5	3	2	(1)	(1)	1	25	4	(1)
July	245	175	141	50	13	67	48	128	44	1	5	8	1	(1)	(1)	1	16	4	(1)
August	245	178	92	38	12	64	21	121	23	(1)	6	14	1	0	0	(1)	5	1	(1)
September	271	180	94	23	11	139	23	126	11	(1)	5	8	0	0	(1)	(1)	3	(1)	(1)
October	294	174	137	30	14	208	15	126	7	1	4	8	0	0	0	(1)	4	(1)	(1)
November	258	187	136	12	12	147	14	93	6	3	3	7	0	0	0	(1)	1	(1)	(1)
December	286	178	137	10	11	189	11	94	6	4	(1)	13	0	0	0	2	(1)	(1)	(1)
Year total	2,398	2,536	1,774	549	172	1,039	862	1,188	840	50	52	86	21	2	1	9	67	17	1

¹ Means less than 500.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE F-7.—BENEFIT EXHAUSTIONS UNDER FEDERAL SUPPLEMENTAL BENEFITS (1975–78), FEDERAL SUPPLEMENTAL COMPENSATION (1982–85), AND EMERGENCY UNEMPLOYMENT COMPENSATION (1991–93)

[In thousands]

	Federal supplemental benefits				Federal supplemental compensation				Emergency unemployment compensation ¹		
	1975	1976	1977	1978	1982	1983	1984	1985	1991	1992	1993
January .....	.....	169	91	49	.....	226	225	98	.....	.....	23
February	7	164	80	6	.....	419	168	80	.....	.....	28
March	33	181	96	1	.....	315	145	89	.....	.....	26
April	33	169	97	.....	.....	68	113	83	.....	.....	56
May	73	136	112	.....	.....	113	115	75	.....	.....	174
June	105	129	63	.....	.....	730	95	33	.....	.....	120
July	185	108	49	.....	.....	352	96	.....	.....	.....	336
August	150	103	58	.....	.....	291	94	.....	.....	.....	142
September	149	74	51	.....	.....	300	79	.....	.....	.....	146
October	157	81	119	.....	18	215	90	.....	.....	.....	146
November	145	92	48	.....	350	130	81	.....	(*)	.....	170
December	174	93	35	.....	314	424	81	.....	1	.....	245
Total	1,211	1,499	899	56	682	3,583	1,382	458	1	1,610	2,458

Notes:

*Less than 500.

(1) There was no program in 1979–81 and 1986–90.

(2) Data for August and September 1975 were not available. The \$299,000 difference between the total for the year and the sum of available monthly data was prorated between August and September.

(3) FSC exhaustions are not additive because reachback provisions caused claimants to receive as many as 3 final payments.

(4) Reports were not received from all States for every month for EUC.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services.

TABLE F-8.—UNEMPLOYMENT COMPENSATION PAID BY PROGRAM IN FISCAL YEAR 1993

[In millions of dollars]

State	Programs		Emergency	Total
	Regular	Extended		
Alabama	187	0	73	260
Alaska	104	(*)	63	166
Arizona	182	0	87	269
Arkansas	169	0	79	248
California	3,510	0	2,272	5,782
Colorado	168	0	81	249
Connecticut	535	0	347	882
Delaware	62	0	20	82
District of Columbia	115	0	48	163
Florida	712	0	466	1,178
Georgia	309	0	137	446
Hawaii	161	0	60	221
Idaho	80	0	39	119
Illinois	1,263	0	534	1,797
Indiana	195	0	84	279
Iowa	184	0	68	252
Kansas	176	0	79	255
Kentucky	209	0	91	300
Louisiana	169	0	86	255
Maine	105	0	89	194
Maryland	376	0	208	584
Massachusetts	835	0	499	1,335
Michigan	1,051	0	615	1,666
Minnesota	378	0	141	519
Mississippi	103	0	58	162
Missouri	333	0	182	515
Montana	49	0	19	67
Nebraska	50	0	14	64
Nevada	135	0	60	196
New Hampshire	41	0	27	68
New Jersey	1,239	0	896	2,135
New Mexico	66	0	28	94
New York	2,196	0	1,515	3,712
North Carolina	277	0	202	479
North Dakota	27	0	12	39
Ohio	757	0	433	1,190
Oklahoma	127	0	63	189
Oregon	357	0	212	569
Pennsylvania	1,548	0	1,038	2,586
Puerto Rico	198	(*)	107	306
Rhode Island	157	0	131	289
South Carolina	177	0	87	264
South Dakota	12	0	2	14
Tennessee	242	0	124	366
Texas	1,114	0	571	1,686
Utah	76	0	29	105
Vermont	57	0	25	82

TABLE F-8.—UNEMPLOYMENT COMPENSATION PAID BY PROGRAM IN FISCAL YEAR 1993—Continued

[In millions of dollars]

State	Programs		Emergency	Total
	Regular	Extended		
Virginia	227	0	137	364
Virgin Islands	4	0	NA	4
Washington	695	0	303	998
West Virginia	126	(*)	82	208
Wisconsin	427	0	134	561
Wyoming	25	0	11	36

NA—Not available.

* Less than \$500,000.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance, Division of Actuarial Services. Data include State programs and programs for Federal employees and ex-service members.

TABLE F-9.—U.S. AVERAGE WAGE REPLACEMENT RATE: RATIO OF AVERAGE WEEKLY BENEFIT AMOUNT TO AVERAGE WEEKLY WAGE

Year	First quarter	Second quarter	Third quarter	Fourth quarter	Average
1971	NA	NA	NA	NA	.365
1972	NA	NA	NA	NA	.361
1973	NA	NA	NA	NA	.361
1974	NA	NA	NA	NA	.365
1975 .....	.377	.375	.381	.368	.375
1976 .....	.390	.374	.368	.359	.373
1977 .....	.384	.361	.356	.361	.365
1978 .....	.383	.360	.359	.359	.365
1979 .....	.372	.357	.361	.362	.363
1980 .....	.376	.376	.373	.350	.369
1981 .....	.372	.359	.363	.358	.363
1982 .....	.381	.378	.383	.373	.379
1983 .....	.384	.378	.364	.360	.372
1984 .....	.358	.355	.358	.352	.356
1985 .....	.354	.352	.362	.352	.355
1986 .....	.356	.361	.369	.353	.360
1987 .....	.359	.362	.363	.342	.357
1988 .....	.357	.357	.351	.333	.350
1989 .....	.356	.361	.365	.343	.356
1990 .....	.361	.370	.373	.346	.362
1991 .....	.374	.374	.375	.343	.367
1992 .....	.371	.372	.368	.369	.370
1993 .....	.377	.367	.366	NA	NA

NA—Not available.

Prepared by DOL/ETA/UIS/DAS.

TABLE F-10.—NUMBER UNEMPLOYED 27 WEEKS OR LONGER AS A PERCENT OF ALL UNEMPLOYED (UNADJUSTED)

Year	First quarter	Second quarter	Third quarter	Fourth quarter
1971	8.7	11.1	11.0	10.8
1972	12.1	13.5	10.8	9.8
1973	8.6	8.5	7.0	7.4
1974	6.8	8.3	7.5	7.1
1975	8.7	14.8	18.7	19.1
1976	19.7	20.1	16.7	16.3
1977	15.5	16.5	13.6	12.9
1978	11.1	11.8	10.1	8.7
1979	9.0	9.5	8.1	8.3
1980	8.3	9.9	11.1	13.5
1981	15.3	15.0	13.7	12.3
1982	13.0	16.7	17.1	19.4
1983	23.2	26.3	23.8	21.9
1984	21.0	21.0	17.7	16.5
1985	15.8	16.4	14.7	14.7
1986	13.8	15.0	14.6	14.2
1987	14.0	15.1	13.9	12.9
1988	12.3	12.9	11.7	11.1
1989	10.4	10.5	9.0	9.6
1990	9.5	10.2	10.4	10.2
1991	10.8	12.9	13.6	14.9
1992	17.9	21.4	21.8	21.4
1993	20.4	20.2	20.3	20.6

Source: U.S. Department of Labor.

TABLE F-11.—RATIO OF INSURED UNEMPLOYMENT TO JOB LOSERS

Year	Job losers (thou- sands)	Insured unemploy- ment		Ratio: Insured un- employment to job losers	
		All pro- grams (thou- sands)	Regular pro- grams (thou- sands)	All pro- grams	Regular pro- grams
1968	1,070	1,187	1,111	110.9	103.8
1969	1,017	1,177	1,101	115.7	108.3
1970	1,811	2,070	1,805	114.3	99.7
1971	2,323	2,608	2,150	112.3	92.6
1972	2,108	2,192	1,848	104.0	87.7
1973	1,694	1,793	1,632	105.8	96.3
1974	2,242	2,558	2,262	114.1	100.9
1975	4,386	4,937	3,986	112.6	90.9
1976	3,679	3,846	2,991	104.5	81.3
1977	3,166	3,308	2,655	104.5	83.9
1978	2,585	2,645	2,359	102.3	91.3
1979	2,635	2,592	2,434	98.4	92.4
1980	3,947	3,837	3,350	97.2	84.9
1981	4,267	3,410	3,047	79.9	71.4
1982	6,268	4,594	4,061	73.3	64.8
1983	6,258	3,775	3,396	60.3	54.3
1984	4,421	2,561	2,476	57.9	56.0
1985	4,139	2,693	2,611	65.1	63.1
1986	4,033	2,746	2,650	68.1	65.7
1987	3,566	2,401	2,332	67.3	65.4
1988	3,092	2,135	2,081	69.0	67.3
1989	2,983	2,205	2,158	73.9	72.3
1990	3,322	2,575	2,522	77.5	75.9
1991	4,608	3,406	3,342	73.9	72.5
1992	5,291	3,348	3,245	63.3	61.3
1993 (preliminary)	4,769	2,845	2,751	59.7	57.7

Source: Based on data from the Economic Report of the President, 1994.

TABLE F-12.—NET BALANCES IN STATE UNEMPLOYMENT INSURANCE ACCOUNTS

[In billions of dollars]

End of calendar year—	Actual	1993 dol- lars ¹
1960	6.4	30.6
1961	5.6	26.4
1962	6.0	27.7
1963	6.4	29.2
1964	7.1	31.8
1965	8.2	35.9
1966	9.7	41.0
1967	10.7	43.9
1968	11.7	45.7
1969	12.6	46.9
1970	11.9	42.0
1971	9.7	32.5
1972	9.4	30.0
1973	10.9	32.8
1974	10.5	29.0
1975	3.1	7.8
1976	0.9	2.1
1977	1.0	2.2
1978	4.6	9.5
1979	8.6	16.3
1980	6.6	11.4
1981	5.7	9.0
1982	-2.6	-3.9
1983	-5.8	-8.3
1984	2.2	3.0
1985	10.1	13.3
1986	15.4	19.7
1987	23.2	28.8
1988	31.1	37.2
1989	36.9	42.2
1990	37.9	41.5
1991	30.2	31.9
1992	25.8	26.5
1993	28.2	28.2

¹ Adjusted to 1993 dollars using the implicit price deflator for Gross Domestic Product.

Source: CBO based on data from the "Economic Report of the President"; DOL, "UI Financial Data" and "UI Data Summary."

TABLE F-13.—STATUS OF ADMINISTRATION ACCOUNT (ESAA), FISCAL YEAR 1995
BUDGET

[In billions of dollars]

Fiscal year	1993	1994	1995	1996	1997	1998	1999
FUTA income		4.35	4.43	4.50	4.57	4.63	3.78
Interest earnings .....		.10	.10	.09	.09	.10	.11
General revenue .....		.02	(¹)	.01	.01	.01	.01
State administration (outlays)		3.56	3.50	3.49	3.48	3.47	3.48
UI		2.47	2.40	2.38	2.37	2.36	2.37
ES, BLS, VETS		1.09	1.10	1.11	1.11	1.11	1.11
Federal administration .....		.06	.17	.17	.17	.17	.17
Balance (end of year)	2.22	3.27	2.32	2.40	2.47	2.54	1.65
Ceiling ²	1.42	1.47	1.46	1.45	1.45	1.44	1.44
Excess (shortfall) .....	.80	1.80	.86	.95	1.02	1.10	.21

¹ Less than \$5 million.² Statutory ceiling is 40 percent of current year's appropriation.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1995 President's Budget," Jan. 1994.

TABLE F-14.—STATUS OF EXTENDED BENEFIT ACCOUNT (EUCA), FISCAL YEAR 1995
BUDGET

[In billions of dollars]

Fiscal year	1993	1994	1995	1996	1997	1998	1999
FUTA income		1.09	1.11	1.13	1.14	1.16	0.94
Interest earnings .....		.11	.17	.29	0.41	.54	.68
General revenue advances		3.07	.36				
Overflow from ESAA .....		.80	1.80	.86	.95	1.02	1.10
Advance from FUA							
Repayment of FUA		1.55					
EB outlays—Federal share .....		.05	.07	.15	.18	.18	.18
EUC		3.68					
EUCA balance (end of year) .....	.88	.67	4.03	6.16	8.48	11.02	13.56
Ceiling ¹	8.36	11.64	12.29	12.93	13.53	14.10	14.20
Excess (shortfall)	(7.48)	(10.97)	(8.26)	(6.77)	(5.05)	(3.08)	(.64)

¹ Statutory ceiling is 0.375 percent of covered wages before October 1, 1993, and 0.5 percent after that date.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1995 President's Budget," Jan. 1994.

TABLE F-15.—STATUS OF LOAN ACCOUNT (FUA), FISCAL YEAR 1995 BUDGET

[In billions of dollars]

	Fiscal year						
	1993	1994	1995	1996	1997	1998	1999
Income:							
State repayments		0.50	0.23	0.16	0.20	0.30	0.44
State interest payments ....		.03	.02	.03	.04	.06	.07
Interest earnings .....		.32	.33	.33	.33	.34	.35
Overflow from ESAA							
Repayment from EUCA		1.55					
Outgo:							
State loans		0.52	0.38	0.39	0.38	0.43	0.77
Advance to EUCA							
FUA balance (end of year)	4.22	6.82	6.02	6.15	6.35	6.62	6.71
Ceiling ¹	13.94	5.82	6.14	6.46	6.76	7.05	7.10
Excess (shortfall)	(9.72)	1.00	(.12)	(.31)	(.41)	(.43)	(.39)

¹ Statutory ceiling is 0.625 percent of covered wages before Oct. 1, 1993, and 0.25 percent after that date.

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1995 President's Budget," Jan. 1994.

TABLE F-16.—STATUS OF STATE UNEMPLOYMENT INSURANCE ACCOUNTS—FISCAL YEAR 1995 BUDGET

[In billions of dollars]

	Fiscal year						
	1993	1994	1995	1996	1997	1998	1999
Income							
Collections	23.81	23.89	24.58	25.16	26.03	27.23	
Interest earnings	21.56	22.01	22.56	23.11	23.63	24.23	
Loans	1.73	1.50	1.63	1.67	1.97	2.23	
Excess reduced credits .....	.52	.38	.39	.38	.43	.77	
Outgo							
Benefits	23.28	22.85	23.18	23.73	23.73	24.88	
Lump-sum repayments	22.78	22.62	22.96	23.35	23.46	24.55	
	.50	.23	.22	.18	.27	.33	
Balance (end of year)							
Outstanding loans	28.95	29.48	30.51	32.01	33.64	35.94	38.28
	.22	.25	.40	.63	.81	.93	1.26
Net balance (excluding loans)							
	28.73	29.23	30.11	31.38	32.83	35.01	37.02

Source: U.S. Department of Labor, Employment and Training Administration, Unemployment Insurance Service, Division of Actuarial Services, "UI Outlook: FY 1995 President's Budget," Jan. 1994.

APPENDIX G. DATA ON FAMILIES

SELECTED INDICATORS OF THE STATUS OF CHILDREN

Teenage Pregnancy					
	1973	1980	1985	1989	1990
Female population (ages 15 to 19)	10,193,000	10,381,000	9,174,000	8,840,000	8,645,000
Births	604,096	552,161	467,485	506,503	521,826
Induced abortions	231,900	444,780	399,200	370,900	350,970
Estimated miscarriages	144,010	154,910	133,420	136,390	139,460
Pregnancies	980,000	151,850	100,110	1,015,790	1,012,260

International Infant Mortality Rates (deaths per 1,000 live births)				
	1950-52	1970-72	1980-82	1986-88
Japan	55.9	12.4	7.1	5.0
Sweden	20.9	11.0	6.9	6.0
Canada	39.4	17.8	9.7	7.5
United States (white)	26.0	17.1	10.5	8.7
England and Wales	29.1	17.7	11.3	9.3
United States (total)	28.7	19.2	12.0	10.1
Hungary	77.0	34.7	21.4	17.4
United States (black)	45.1	30.9	20.3	17.8

Out-of-Wedlock Births				Percent Change 1980-91
	1980	1990	1991	
Under age 15	9,024	10,675	10,968	21.5
Ages 15 to 19	262,777	349,970	357,483	36.0
Ages 20 to 24	237,265	403,873	429,094	80.9
Ages 25 to 29	99,583	229,991	234,593	135.6
Ages 30 to 34	40,984	118,200	123,901	202.3
Ages 35 to 39	13,187	44,149	48,353	266.7
Age 40 and over	2,927	8,526	9,377	220.4
Total (ages 15-44)	665,747	1,165,384	1,213,769	82.3

Living Arrangements of Children Under Age 18 (in thousands)				
	1960	1970	1980	1990
Total in population	63,727	69,162	63,427	64,137
Living with 1 parent	5,829	8,199	12,466	15,867
Percent of all children	9.1	11.9	19.7	24.7
Living with never-married parent	243	557	1,820	4,853
Percent of all children	0.4	0.8	2.9	7.6

Children Below Poverty (number in thousands/rate per 1,000)					
	1974	1979	1989	1990	1992
Total	10,156 (15.4)	10,377 (16.4)	12,590 (19.6)	13,431 (20.6)	14,617 (21.9)
Black	3,755 (39.8)	3,833 (41.2)	4,375 (43.7)	4,550 (44.8)	4,938 (46.6)
White	6,223 (11.2)	6,193 (11.8)	7,599 (14.8)	8,232 (15.9)	8,955 (16.9)
Hispanic	NA (NA)	1,535 (28.0)	2,603 (36.2)	2,865 (38.4)	3,116 (39.9)

Educational Achievement					
High school dropouts (percent-age of status dropouts, ages 18-24)					
	1970	1975	1985	1990	1991
Total	17.3	15.6	13.9	13.6	14.2
White	15.2	13.9	13.5	13.5	14.2
Black	33.3	27.3	17.6	15.1	15.6
Average SAT scores					
	1970	1975	1985	1990	1993
Verbal	460	434	431	424	424
Math	488	472	475	476	478

NA: not available

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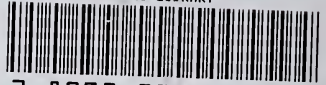


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